

2015

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Recommended Citation

DeMoss, Lisa Sewell (2015) "Health Care Reform and States' Rights: Did We Learn Anything from the Civil War?," *Saint Louis University Public Law Review*. Vol. 34 : No. 2 , Article 5.

Available at: <https://scholarship.law.slu.edu/plr/vol34/iss2/5>

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**HEALTH CARE REFORM AND STATES' RIGHTS:
DID WE LEARN ANYTHING FROM THE CIVIL WAR?**

LISA SEWELL DEMOSS*

The election of Abraham Lincoln in November of 1860 marked a turning point for Southern states in the debate over settlement of the western territories and their future participation in a national economy. At the time, Northern states were launching an industrial revolution and a movement towards a more urban, capitalist economy. The South remained largely an agrarian economy supported by slave labor and controlled by wealthy plantation owners. Northerners and many Southerners were conflicted over the perpetuation of slavery in America for reasons rooted in religious, philosophical, political, and moral differences. Notwithstanding impassioned advocacy by abolitionists and conflicting national views on slavery itself, the political debate centered on perpetuation of a slave-based labor force to settle and develop the western territories. Slavery was embedded in the Southern states' economy and culture. The Southern states possessed a unity of purpose in maintaining their economic model for farming, not only with regard to the settlement of new territories in the West, but also in their home states. Moreover, slavery preserved institutional class distinctions affecting all of Southern society. Northern politicians of that era were reluctant to mount a frontal attack on the institution of slavery, opting instead to focus their mission as one of containment.

During the first few months of Lincoln's presidency, eleven Southern states seceded from the union of states bound together by the Constitution. Civil war ensued, motivated by divergent perspectives on federalism and concerns over the political agenda of the new president and his Republican Party. The Confederacy of Southern States was formed to protect Southern interests from the assault on slavery and the economic interests it represented. The seceding states felt justified in withdrawing from their union with Northern states based upon an interpretation of the United States Constitution with regard to the protection and advancement of their rights as individual states whose critical interests were under attack.

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Just as the Fugitive Slave Act of 1850 engaged an entire nation in debate on the issue of slavery, this nation's efforts to address the economic impact of unaffordable health care has launched a maelstrom of conflict, dividing Americans into two camps: those with health insurance and the uninsured. After decades of failed attempts to address the worsening situation, Congress, under the direction of President Barack Obama, passed comprehensive health care reform legislation in 2010. Opposition was immediate and increasingly belligerent. In this well-coordinated attack, opposition assumed many forms, including pre-enactment nullification actions by state legislatures, minority-party congressional votes to repeal the legislation in its entirety, litigation, congressional refusals to fund its implementation, state refusals to enact critical state components of the comprehensive market reform provisions, and political penalties exacted for supporting the law. Within individual states, governors have been pitted against elected attorneys general, each arguably advancing the interests of the citizens of their respective states. Economic and social conservatives demand greater individual accountability for financing personal health care needs. They rail against those advocating a human right to access health care, disparaging government-subsidized access for those who cannot afford it. Conservatives and Libertarians found common ground in their belief that health care is a privilege or matter of personal responsibility, the cost of which should be borne by the individual consumer of health care services, not the government.

In 2012, in the first of three decisions challenging the Patient Protection and Accountability Act of 2010, the Supreme Court upheld the constitutionality of a key feature of health care reform, the individual coverage mandate, while simultaneously concluding that another fundamental element of the legislation exceeded congressional constraints under the necessary and proper clause. A majority of justices agreed to preserve the balance of the act. Yet, the Court, like Congress and the rest of the country, remains divided on basic values and government responsibility for providing health care. This assures that political, legislative, and litigation challenges to the legislation will continue.

Just as Southern landholders fought to retain their economic model for farming, Americans with access to health care fight to retain a health care economy in which those who have the means to access necessary care reject the burden of financing health care for those who cannot afford to buy what they need. This is a battle waged between powerful and protected Americans who support the market-based interests of the ever-expanding American health care economy and advocates for individuals for whom health care and good health have become an unaffordable commodity. There remains significant disagreement over the role of government, either state or federal, in financing the cost of care for those who either elect not to purchase health insurance or cannot afford to purchase necessary services on their own. Individual opinion

may be a reflection of religious or moral beliefs, but the issues are joined on the modern battlefield of limited government versus an expanded welfare state.

Can we afford a protracted constitutional battle over states' rights, individual liberties, and how to finance health care for those who cannot afford to participate in the American health care economy? How long can the states afford to manage the cost of indigent and uninsured health care without additional federal assistance? And, should the campaign to repeal health care reform legislation succeed, how long can the United States economy labor under the cost of modern health care, disproportionate not only in relation to other industrial nations' cost, but also with regard to its failure to deliver significantly better health status in exchange for a disproportionately higher cost? This essay examines and compares our antebellum history and post-Civil War reconstruction efforts to the unharmonious and antagonistic atmosphere permeating modern debate over health care. It concludes that these two periods of American history share many similar cultural, ideological, religious, moral, and political attributes which impede the development of consensus solutions and political compromise.

I. THE ECONOMIC IMPERATIVES OF REFORM

Fortunately, medicine has advanced significantly since the mid-1800s. The United States has led the world in innovation and evolution of its health care delivery system. But, by any measure, we have a health care financing crisis in America today. Health care expenditures now exceed one-sixth of the national economy.¹ In 2010, we spent over \$2.6 trillion on health care, or \$8,042 per person.² This sum represents 17.9% of America's gross domestic product (GDP).³ We spend 48% more on a per capita basis than Switzerland, which equates to a 5% greater comparative portion of our GDP.⁴ To put these figures in context, Americans spend approximately twice as much on health care as we spend on food.⁵ Moreover, since 2000, health insurance premiums have increased at a rate of 3%–13% consistently.⁶ During that same period, wages have only increased at a rate of 2%–4%, requiring greater portions of workers' income every year to cover the increased premium cost.⁷ Over time, as premiums have increased, wages have stagnated and employers have

1. 42 U.S.C. § 18091(2)(B) (2012).

2. HENRY J. KAISER FAMILY FOUND., HEALTH CARE COSTS: A PRIMER 1 (May 2012), available at <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7670-03.pdf>.

3. *Id.*

4. *Id.* at 7.

5. DIANA FARRELL ET AL., MCKINSEY GLOBAL INST., ACCOUNTING FOR THE COST OF US HEALTH CARE 9 (Dec. 2008), available at http://www.mckinsey.com/insights/health_systems_and_services/accounting_for_the_cost_of_us_health_care.

6. HENRY J. KAISER FAMILY FOUND., *supra* note 2, at 18.

7. *Id.*

transferred annual premium cost increases onto their employees in the form of premium contributions and increased health care deductible and copayment cost sharing. Between 1999 and 2011, the average employee premium contribution for a family group health plan increased from \$1,543 per year to \$4,129 per year.⁸

Before adoption of the Patient Protection and Affordable Care Act of 2010 (ACA), there were an estimated fifty million uninsured Americans.⁹ This number marks a substantial increase over the levels of uninsured prior to the recession of 2009–2010, during which many Americans lost access to employer-sponsored group health insurance due to the loss of their jobs. This period of time marked the highest level of unemployment in twenty-seven years.¹⁰ States' economies were impacted differently and recovered at different rates. To the extent individuals were reemployed, many have taken lower-paying service-sector jobs, which typically do not include employer-sponsored health insurance as a benefit of employment.¹¹ The post-recession labor market posted the lowest adjusted income figures since 1996.¹² Competitive pressures to maintain product and service costs discourage these employers from adding to their labor costs by providing group health insurance. And, notably, small employers, particularly those within the service sector, represent the fastest-growing post-recession segment of the American economy.¹³

Despite the cost, employers continue to compete for qualified workers not only on the basis of competitive wages, but also by offering comprehensive health plans and other employment benefits. Although the number has declined recently, 51% of insured Americans acquire access to health care today through employer-sponsored group health plans.¹⁴ These benefits are tax-free to employees and the cost is tax-deductible for employers.¹⁵ Six percent of Americans are enrolled through private, non-group or individual policies providing health care coverage.¹⁶ Public programs such as Medicare (15%), Medicaid (12%), and military health care (1%) provide health care coverage

8. *Id.* at 19.

9. See FREDRIC BLAVIN ET AL., URBAN INST., UNINSURANCE IS NOT JUST A MINORITY ISSUE: WHITE AMERICANS ARE A LARGE SHARE OF THE GROWTH FROM 2000 TO 2010 (Nov. 2012), available at <http://www.urban.org/uploadedpdf/412698-uninsurance-is-not-just-a-minority.pdf>.

10. *See id.*

11. *Id.*

12. *Id.*

13. *Id.*

14. COMMONWEALTH FUND, INTERNATIONAL PROFILES OF HEALTH CARE SYSTEMS 128 (Nov. 2013), available at http://www.commonwealthfund.org/~media/files/publications/fund-report/2013/nov/1717_thomson_intl_profiles_hlt_care_sys_2013_v2.pdf.

15. *Id.* at 129.

16. *Id.* at 128.

for 28% of Americans.¹⁷ In 2011, that left fifty million Americans, or 16% of the American population, without access to health care coverage.¹⁸ And, of those who are uninsured, three-quarters fall into the category of working poor.¹⁹

The greatest number of uninsured Americans live in southern or western states.²⁰ Before implementation of the ACA, Nevada, Texas, New Mexico, and Florida each managed uninsured patient populations accounting for 24% or more of their state residents.²¹ Financing the essential health care needs of these individuals places extraordinary strain on state budgets. In 2008, uncompensated medical care accounted for \$57 billion in spending across the country.²² Hospitals provided 60% of that care.²³ Of that 60%, the federal government compensated hospitals for about 50% of those losses through factors built into their Medicare and Medicaid payment rates.²⁴ State governments share in the cost of those Medicaid payments to health care providers located within their respective states. The remaining 50% was satisfied in whole or in part by charity, patient contributions, or bad debt write-offs.²⁵ Doctors receive no government reimbursement of bad debt losses attributable to unpaid medical services.²⁶

The health care delivery system passes these losses onto consumers by increasing prices. These take the form of higher rates in contracts negotiated between hospitals and private payers, notably health insurers.²⁷ Insurers pass higher claim costs through to purchasers by raising premiums.²⁸ Self-insured group health plans are also the direct recipients of health care provider price increases under their contracts with administrators who price claims arising under their networks of contracted health care providers.²⁹ It is estimated that each insured patient in America pays an extra \$1,000 per year in premium cost or direct cost of claims in the form of cost shifts to cover health care provider losses incurred when treating uninsured patients.³⁰

17. *Id.*

18. *Id.*

19. JAMES R. TALLON ET AL., HENRY J. KAISER FAMILY FOUND., THE UNINSURED: A PRIMER 1 (2013), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/10/7451-09-the-uninsured-a-primer-key-facts-about-health-insurance.pdf>.

20. *Id.* at 8.

21. *Id.*

22. *Id.* at 15.

23. *Id.*

24. *Id.*

25. TALLON ET AL., *supra* note 19, at 13.

26. *Id.* at 15.

27. *Id.*

28. 42 U.S.C. § 18091 (2)(F)(2012).

29. 42 U.S.C. § 18091 (2)(J).

30. 42 U.S.C. § 18091 (2)(F).

Access to affordable health care either through insurance protection or community health centers has been directly linked to overall health status.³¹ For the uninsured in America, lack of access to primary care services results in later detection of curable forms of cancer, producing higher rates of mortality.³² Cancer screenings for prostate, ovarian, breast, and colorectal cancer have had a significant impact on survival rates for those common forms of disease by providing earlier detection and immediate treatment upon diagnosis.³³ When compared to insured patients, uninsured cancer patients are 50% to 300% more likely to be diagnosed with one of these types of cancers only after the cancer has advanced to stage three or four.³⁴ Later diagnosis results in a 65% to 76% negative survival disparity after five years.³⁵

Lack of access to regular treatment for chronic conditions such as diabetes, heart disease, and hypertension leads to medical complications, impairment of quality of life, and premature death for uninsured patients.³⁶ Overall, the uninsured suffer from more frequent hospitalizations, greater physical disability, and shorter lifespans.³⁷ The Commonwealth Fund publishes scorecards comparing and analyzing the performance of health care systems nationally and internationally. In its 2014 state scorecard report, it observed that there is considerable geographic disparity in America in the quality and performance of local health systems.³⁸ The Commonwealth Fund report notes that states influence system performance in many ways: by purchasing care for low-income populations as well as their own employees (who collectively often form the largest group health plan in a state), by regulating health care providers and health insurers and their markets, by setting a statewide health information technology strategy, by supporting public health, and by serving as both facilitator and collaborator for health care system improvements.³⁹ The report, which measures performance across forty-two different indicators of

31. HENRY J. KAISER FAMILY FOUND., *THE UNINSURED AND THE DIFFERENCE HEALTH INSURANCE MAKES 2* (2012), available at <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/1420-14.pdf>

32. INST. OF MED., BD. ON HEALTH CARE SERVS., *COMM. ON THE CONSEQUENCES OF UNINSURANCE, CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE* 57 (2002).

33. *Id.* at 56.

34. *Id.*

35. HENRY J. KAISER FAMILY FOUND., *supra* note 31, at 2 (reporting that uninsured adults are less likely to receive preventative care and are two times more likely to delay or forgo needed care than the insured, which increases the likelihood of hospitalization for avoidable conditions); INST. OF MED., *supra* note 32, at 57 (discussing how uninsured patients with these chronic illnesses experienced worse clinical outcomes).

36. DAVID C. RADLEY ET AL., COMMONWEALTH FUND, *AIMING HIGHER: RESULTS FROM A SCORECARD ON STATE HEALTH SYSTEM PERFORMANCE* 28 (2014).

37. *Id.* at 29–30.

38. *Id.* at 9.

39. *Id.* at 29.

access, quality, and cost of health care, observes a correlation between low rates of access to preventive care and poor health outcomes.⁴⁰ Top-performing states like Vermont, Massachusetts, Minnesota, New Hampshire, and Hawaii invested in primary care access, disease prevention, and chronic disease management.⁴¹ Their strategies were characterized by adoption of joint federal-state health care initiatives, such as Medicare pilot programs, that are directed towards improving quality while enhancing the efficiency of hospital service delivery.⁴² These collaborative projects benefit not only Medicare patients, but also all other patients receiving services in those participating hospitals.

Bottom-performing states are distinguished by lower-wage job markets and higher rates of poverty, obesity, chronic disease, and disability.⁴³ Sixteen of the bottom twenty-six states declined to expand Medicaid eligibility under the ACA.⁴⁴ This means that they have elected to pass on federal grants covering 100% of the short-term cost of expanding state Medicaid program eligibility to uninsured adults with incomes at or below 133% of the federal poverty level.⁴⁵ For reasons that will be explored later in this essay, the leadership in these states have chosen to reject an expansion of their existing partnership with the federal government. That Medicaid partnership program provides health care access to the neediest Americans under a financing arrangement through which costs are shared between the federal and state governments. The federal solution to covering the uninsured through expansion of the Medicaid program was, therefore, rejected in favor of more local solutions to financing uncompensated care for these individuals. These decisions are rooted in apprehension over the role of government in health care delivery and financing markets and the rights of individuals to be free from government intrusion into the most personal of individual liberties involving one's health. These actions have perpetuated and exacerbated inequalities in access to necessary health care services. As noted in the Commonwealth Fund's scorecard, where you live matters in America, and the quality and length of your life are dependent in large measure on your ability to acquire access to necessary health care services.

II. WHY ARE WE FIGHTING OVER HEALTH CARE?

Everyone has an opinion about health care. Those opinions are formed and reshaped by every encounter with the health care delivery system, whether as a patient, an observer, provider, or payer. Those who are immune from

40. *Id.* at 29, 31.

41. *Id.* at 29.

42. RADLEY ET AL., *supra* note 36, at 13.

43. *Id.* at 28.

44. *Id.* at 30.

45. *Id.*

interaction with health care systems due to the good providence of reasonably perfect health, as well as their supporters in the economic debate, harbor opinions regarding whether they should be allowed to purchase health care on an as-needed basis. Others, who are well protected against the financial consequences of an adverse health event through health insurance or adequate savings, feel at best indifferent to the plight of those who cannot afford that same market access. The differences are philosophical, religious, moral, and political. Their roots can be traced back to the formation of our nation and the difficult choices we have confronted with regard to funding individual versus government responses to needed services.

It is unclear whether Americans generally agree that there is a problem that needs to be addressed with regard to providing broader access to necessary health care services. One's perspective on that topic seems to be influenced by whether the health care needs of your family are being met and whether you feel any particular empathy for those whose needs are not similarly being met. It also appears to be influenced by where you live, your economic status, and your views on personal responsibility and accountability. Not unlike our predecessors during the antebellum period of American history, we are conflicted over the significance of this issue to our economy and social security.

Political and judicial views on health care reflect these popular perspectives as well as fundamental differences of opinion regarding federalism and the rights of states and individuals to exercise control over health care as a significant element of commerce within and among the states and as a matter of individual liberty affecting very personal choices regarding health, safety, and welfare. These views can be traced back in history to the establishment of our federal government and the struggle to delineate and limit the foundational concepts of dual sovereignty and the protection of individual liberties.

III. FEDERALISM AND THE EVOLUTION OF THE NULLIFICATION "REMEDY"

In 1861, only about one-third of the families in the eleven states that seceded from the Union owned slaves. Yet, despite divergent religious, moral, and philosophical misgivings about slavery within these states,⁴⁶ they fought a costly civil war to protect slavery as a cultural institution and foundation of

46. ELIZABETH R. VARON, *DISUNION! THE COMING OF THE AMERICAN CIVIL WAR, 1789–1859*, at 82–83 (2008) (Evangelical Christians, who dominated both Northern and Southern cultures at the time, defended slavery as a “positive good” based on the premise that the profitability of Southern slaveholding reflected their moral virtue); REID MITCHELL, *THE AMERICAN CIVIL WAR, 1861–1865*, at 7 (2001) (noting that a petition was submitted on December 14, 1831 by Virginia Quakers to the Virginia General Assembly seeking the abolition of slavery in the commonwealth).

their agrarian economy. At various times, Georgia's, South Carolina's, and Mississippi's leaders publicly stated that the preservation of slavery was their primary motivation for secession.⁴⁷ During the antebellum period, slavery and abolition were debated in the larger context of shared concern over how capitalism would transform the nation, particularly with regard to settlement of the West.⁴⁸ Professor Hartnett writes about the lyceum movement of that time. This debate became a popular form of communication, which incorporated the use of print media to address mass audiences of "like-minded Americans" using "cultural authority" to teach fellow citizens how to be good citizens by understanding their rights, duties, and authority.⁴⁹ While the lyceum movement was perceived at the time as an enlightened public forum of debate, instruction, and entertainment, it also had its detractors. The Honorable Theodore Frelinghuysen observed in 1832 that the lyceum had less to do with nationalism than class privilege and the ability to impose values and normative behaviors on the masses.⁵⁰ This form of mass communication has been perfected over the years. Modern cable television and radio broadcast news, with programming specifically directed separately towards conservative and more liberal audiences, serve a similar purpose in modern culture. Americans' ability to access political news on a twenty-four-hour saturated content basis over the Internet and through print and broadcast media has influenced public opinion and routed "like-minded" individuals into more extreme and strident positioning on social and political issues, including health care.

The origins of the Civil War are linked to a number of divergent ideas and events related to the capitalist transformation of the United States and the autonomy of the states. Their philosophical and ideological roots can be traced back to early periods of American history and the initial framing of the Constitution. The framers of the Articles of Confederation, adopted for ratification by the states in November of 1777, were particularly focused on avoiding a national government that functioned like the British Parliament.⁵¹ The articles established a confederacy of sovereign states. Article II stated that "each state shall retain its sovereignty, freedom and independence, and every Power . . . which is not by this confederation expressly delegated to the United States, in Congress assembled."⁵² Those central powers were limited to foreign relations, regulating trade with the Indians, controlling the navy, coining

47. MITCHELL, *supra* note 46.

48. STEPHEN J. HARTNETT, *DEMOCRATIC DISSENT AND THE CULTURAL FICTIONS OF ANTEBELLUM AMERICA* 1 (2002).

49. *Id.* at 173.

50. *Id.* at 174–75.

51. *See generally* ROBERT P. SUTTON, *FEDERALISM* 3–8 (2002).

52. ARTICLES OF CONFEDERATION OF 1781, art. II.

money, and resolving disputes between the states.⁵³ Congress was prohibited from imposing taxes or duties, regulating interstate commerce, or otherwise interfering in the internal affairs of each state.⁵⁴ States were not bound to honor congressional resolutions.⁵⁵ There was no judicial system designated within the articles and states were given wide latitude to determine and regulate trade within their boundaries.⁵⁶

The Articles of Confederation came under immediate criticism after the conclusion of the Revolutionary War. Congress was pressured to convene a meeting to consider revisions. The delegates to that convention perceived the need for a stronger central government to promote foreign policy and develop post-war trade, manufacturing, and commerce. During the debate, delegates James Madison, George Washington, and James Wilson led the group that would later become the Federalists, directing an effort to rewrite the Articles of Confederation in a manner that would strengthen the central government. They prevailed in the adoption of the new United States Constitution that specified a consolidated central government with enumerated powers, while reserving to the states authority over the health and safety of their citizens.⁵⁷ Article I, Section 8, Clause 18 expressly granted authority to Congress to “make all Laws which shall be necessary and proper for carrying into Execution” those powers vested in the federal government.⁵⁸

During the national Constitution ratification contest, an Antifederalist coalition led by George Mason and Elbridge Gerry argued against the potential abuses of federalism, seeking express limitations on the exercise of coercive federal power, while preserving liberty, individual rights, and greater state sovereignty.⁵⁹ The Federalists carried the vote at the Constitutional Convention, but the Antifederalists perpetuated the debate throughout the ratification process. In a series of essays written by John Jay, James Madison, and Alexander Hamilton in support of New York’s ratification of the Constitution, they argued persuasively for a strong central government, subject to a series of checks and balances imposed by the presidential veto power and the review, and possible nullification, of the acts of Congress by a supreme court.⁶⁰ In response to the Antifederalist position on personal liberties, the Federalists promised to prioritize the development of a bill of rights.

53. *Id.* at art. IX, para. 5.

54. *Id.* at art. IX, para. 4.

55. *Id.*

56. *Id.* at art. IX, para. 1.

57. SUTTON, *supra* note 51.

58. U.S. CONST. art. I, § 8, cl. 18.

59. SUTTON, *supra* note 51.

60. *Id.*

James Madison chaired the committee designated by the House of Representatives to prepare a bill of rights. As initially adopted, the Bill of Rights limited the power of Congress and had no effect on the rights of individuals under state laws.⁶¹ Shortly after adoption, permanent political parties emerged. Their ideologies diverged with regard to economic policies, the centralized authority of the federal government, and foreign policy. The Federalist Party assumed control in Congress. Over the objections of what was then the Republican Party, Congress passed the Sedition Act of 1798, which was designed to suppress opposition to the Federalist agenda.⁶² This act punished those who wrote, printed, or stated "false, scandalous and malicious" statements against the federal government.⁶³ In reaction to the prosecution and conviction of several Republicans, Thomas Jefferson and James Madison anonymously published the Kentucky and Virginia Resolutions arguing that the Constitution gave common law jurisdiction to the states exclusively, and states could therefore nullify such laws.⁶⁴ It would take many more years to resolve these fundamental differences over dual sovereignty. Questions regarding the scope of individual liberties and government infringement of those rights continue to the present.

President John Adams appointed John Marshall the third chief justice of the Supreme Court. The Marshall Court, through a series of rulings between 1810 and 1832 beginning with *McCulloch v. Maryland*,⁶⁵ established the Constitution as the "supreme law of the land" and the authority of the federal courts to review the laws of Congress. In *Cohen v. Virginia*,⁶⁶ state court decisions were subjected to federal court review and could be overturned if determined to be in violation of the Constitution. In *Gibbons v. Ogden*,⁶⁷ the Court found not only that interstate commerce was within the exclusive control of Congress but that it also extended to commerce within states that has a significant effect on interstate commerce. In *Gibbons*, Chief Justice Marshall established that the commerce power extends "to all the external concerns of the nation, and to those internal concerns which affect the States generally," excluding *only* those concerns "completely within a particular State" and "which do not affect other States."⁶⁸ And, with regard to matters arising within federal jurisdiction, he noted that Congress's power "acknowledges no limitations, other than are prescribed in the Constitution."⁶⁹

61. *Id.*

62. Alien and Sedition Acts, S. 2, 5th Cong. (1798).

63. *Id.*

64. SUTTON, *supra* note 51.

65. 17 U.S. 316, 327 (1819).

66. 19 U.S. 264, 304-05 (1821).

67. 22 U.S. 1, 195 (1824).

68. *Id.*

69. *Id.* at 196.

The rulings of the Marshall Court were not universally embraced across the nation. In 1828, Vice President John Calhoun anonymously authored *The South Carolina Exposition and Protest*, expanding upon the views espoused in the Virginia and Kentucky Resolutions that the Constitution is merely a compact among sovereign states, allowing any state to prevent the enforcement of an unconstitutional law passed by Congress.⁷⁰ Once states determine a federal law to be unconstitutional, they could prevent its enforcement by state legislation or enactment nullifying the federal law.⁷¹ Calhoun objected to a protective tariff on European imports enacted by Congress in 1828, which disproportionately impacted Southern states that were dependent on imported goods to supplement their staple-crop economies.⁷² He argued that the tariff was an unfair tax on Southern planters that benefitted Northern factory owners, in violation of Article I, Section 8, which specified that duties be uniform throughout the United States.⁷³ Because the tariff violated the Constitution, Southern states could prevent its enforcement based on a breach of the constitutional compact among sovereign states.

Thus began the political debate over states' rights and the availability of nullification as a means to avoid the effects of federal legislation supporting the economic development of the nation. The South generally viewed Congressional actions to favor Northern states' commercial interests. They debated the proposition of whether the nation was a compact among the states or a union of the people.⁷⁴ South Carolina never submitted to the 1828 tariff and, at a nullification convention, enacted an ordinance that nullified the tariff and threatened secession if the United States government tried to enforce the nullified law.⁷⁵ The South Carolina legislature then voted to assemble a military force to protect the state against the use of force by the federal government.⁷⁶ It was the only state that nullified the tariff through state legislative action, but its bold action inspired politicians throughout the South to defend the Southern states' rights to protest unpopular federal laws perceived to disadvantage their agrarian economy in favor of Northern trade interests. Throughout the ensuing political debate over the use of nullification as a key element of a secession strategy, South Carolina's chief statesman,

70. SPECIAL COMM. OF THE HOUSE OF REPRESENTATIVES, SOUTH CAROLINA EXPOSITION AND PROTEST 43 (1828).

71. *Id.* at 41.

72. *Id.*

73. *Id.* at 42.

74. See STEVEN E. WOODWORTH, CULTURES IN CONFLICT THE AMERICAN CIVIL WAR 3-4 (2000) (stating that Daniel Webster criticized nullification as a violation of the Constitution that would lead to civil feuding; he further noted that the nation is a union of the people, not a compact of the states).

75. VARON, *supra* note 46, at 94.

76. *Id.*

John C. Calhoun, unsuccessfully attempted to argue that the purpose of nullification was preservation, not destruction of the Union. President Andrew Jackson issued a proclamation effectively nullifying nullification, declaring it to be an unconstitutional and treasonous act when supported by the use of armed force by the states.⁷⁷ In 1833, bowing to a reduced compromise tariff and force bill enacted by Congress, and preferring compromise to civil conflict, South Carolina rescinded its nullification ordinance.⁷⁸ Yet, nullification as a manifestation of states' rights continued to be advanced by South Carolina's plantation owners as the best option for consolidation of their political power and the preservation of their slave-based economic interests.

During the period of the nullification crisis, there were essentially three competing constitutional doctrines shaping the political debate. National Republicans preferred a broad interpretation of Article I, Section 8, under which implied powers were delegated to the national government by language that specified that Congress could "make all Laws which shall be necessary and proper" for executing its authority under the Constitution.⁷⁹ Nullifiers believed in the separate sovereignty of each state, claiming that it was the bond of the people that supported a union of states, entitling states to break from that union once any given state broke the bond.⁸⁰ The third political faction, states' rights Democrats, believed in a government of delegated, not implied, power, while rejecting the nullifiers' view that states were permitted to determine the constitutionality of federal law.⁸¹

IV. MOUNTING CONCERN OVER ECONOMIC DISPARITIES AND LOSS OF CONTROL

During the 1850s, the United States was experiencing extraordinary economic growth. Yet, the South's dependency on slave labor as both an economic reality and cultural norm slowed its adoption of industrialization and the economies of scale and efficiency it offered.⁸² Thus, the South continued to invest in slave ownership rather than threshing machines, cotton gins, and reapers, causing its industrial development to lag behind that of the increasingly industrialized Northern states.⁸³ At the time, Americans generally believed that slavery was particularly suitable for cultivation of large quantities

77. *Id.*

78. *Id.*

79. *Id.*

80. *Id.*

81. VARON, *supra* note 46, at 94.

82. *Id.*

83. *See* WOODWORTH, *supra* note 74, at 25.

of staple crops such as tobacco, cotton, rice, and sugar, all of which grew predominantly in the warmer southern climate.⁸⁴

Despite its slow adoption of industrialization of farming, the South nonetheless prospered during the period leading to the Civil War. That prosperity was directly linked to the growth and trade of tobacco and wheat in Virginia and Maryland, cotton and sugar in Louisiana and Texas, cotton and rice in North and South Carolina, and cotton throughout the balance of the South.⁸⁵ These crops were produced predominantly through slave labor. By the start of the Civil War, the ratio of slaves to whites residing in the South was 3.5 million to 5.5 million.⁸⁶ Clearly, slaveholding was a major component of the Southern economy, both in terms of investment and production. Yet, wealth was concentrated among the large plantation owners. Southern farmers did not own slaves, although they aspired to do so as a means of acquiring greater wealth and social status.⁸⁷ Southern social and political venues were dominated by the wealthy plantation owners and they enjoyed the highest rank of Southern power and prominence.⁸⁸ During the 1850s, in the state of Mississippi, slaveholders consolidated their control over the state legislature by holding 80% of the elected seats.⁸⁹

The profitability of cotton on world markets drove up the price of slaves. Moreover, the Southern slaveholder reliance on cotton and tobacco crops forced the South into increasing dependency on the North for imported food. The cost of slaveholding and running larger plantations created economic challenges for the largest farming operations and impaired the availability of capital to invest in farm machinery that could improve farming profits. Southern politicians, almost all of whom were slaveholders during this period, espoused the view that the “peculiar institution” of slavery offered smaller Southern farmers economic security while ensuring the equality of whites who would be spared menial work that could be performed by slaves.⁹⁰ The experience of the Southern family farmer was closer to that of a Northern family farmer than a Southern plantation owner. Yet, Southern family farmers fought in the Civil War, having been encouraged by political rhetoric that the perpetuation of slavery assured their social status. They seemingly overlooked the point that the institution of slavery presented an insurmountable competitive threat to the expansion and profitability of their own family

84. *Id.*

85. *Id.* at 30.

86. *Id.*

87. *See id.* at 31.

88. *Id.*

89. HINTON R. HELPER, *THE IMPENDING CRISIS OF THE SOUTH: HOW TO MEET IT* 42 (1857).

90. DAVID WILLIAMS, *BITTERLY DIVIDED: THE SOUTH'S INNER CIVIL WAR 2* (2008).

business. Of the South's free population, three-quarters owned no slaves.⁹¹ In order to consolidate political control and protect the property interests of the plantation owners, it became essential that Southern farmers perceive an alignment with the cultural and social values of the South.

Additionally, slaves were becoming more difficult to control due to increasing resentment and resistance. Privately, slaveholders became increasingly concerned that the national political debate over the expansion of slavery might encourage further Southern dissent among impoverished farmers and resistance among the slaves, making it even more difficult to maintain order on the plantations.⁹² Indeed, at the outset of the Civil War, half of the personal income of the South was concentrated within a group of one thousand families.⁹³ The widening gap between the wealthy and the poor and the perceived lack of upward mobility created regional animosity that fostered disunity and disagreement over secession as a necessary counterbalance to the prevailing national political sentiment.

The prevailing religious sentiment in the Northern states was a blend of New England Puritan views on "honesty, thriftiness, virtuosity and industriousness" and the Dutch and Protestant work ethic. These Northern cultural views supported and rewarded individual accomplishment and the value of freely offered labor. In combination, these cultural, religious, and agricultural beliefs resulted in the proliferation of slavery in the South and its rejection by virtually every Northern colony and state. As the North diversified its economy to include manufacturing and trade, in addition to agriculture, Northern farm operations remained essentially family owned. Northern farmers were united in their rejection of slavery. They did not want their own hard labor to be replaced through competition with plantation-based, slave-driven agricultural production.⁹⁴ They were self-sufficient, producing food for family consumption as well as a surplus for food markets.⁹⁵ They did not want to be viewed as the social equivalents to slaves.⁹⁶

Politicians of the day recognized the challenge that slavery presented when developing an election strategy. Abraham Lincoln, who ran on the Republican Party ticket in 1860, believed that slavery was morally wrong but urged that slavery be contained to the South so that the western territories could be developed with free labor.⁹⁷ At the time, the Republican Party was composed of Northern Whigs, abolitionists who were willing to compromise for limited

91. *Id.*

92. *Id.*

93. ERIC FONER, *POLITICS AND IDEOLOGY IN THE AGE OF THE CIVIL WAR* 21 (1980).

94. *Id.* at 22.

95. *Id.* at 24.

96. *Id.*

97. *Id.* at 19.

slavery, former Free-Soilers, and some Northern Democrats.⁹⁸ In order to consolidate his political authority, Lincoln framed the slavery controversy as a matter of importance to the economic future of the country, linked inextricably to the manner in which the western territories were developed.⁹⁹

During the decade leading to his presidency, the country debated the premise of the Missouri Compromise of 1850, which was intended to quell Southern objection to congressional efforts to prohibit the expansion of slavery in the territories acquired during the war with Mexico.¹⁰⁰ These territories would later become California, Utah, and New Mexico.¹⁰¹ The Missouri Compromise renewed debate over federalism and the power of Congress to abolish slavery. A portion of the compromise included the Fugitive Slave Act of 1850, which required the capture and return of runaway slaves.¹⁰² Northern states opposed to the institution of slavery, including Pennsylvania and Wisconsin, enacted laws to nullify the duties to return slaves to their Southern owners.¹⁰³ In two separate cases,¹⁰⁴ the Supreme Court upheld the Fugitive Slave Act as an appropriate exercise of congressional authority.

In 1857, the Supreme Court found the Missouri Compromise to be an unconstitutional effort to exclude slavery (which was legal at that time) from the territories.¹⁰⁵ Relying upon the Fifth Amendment, the Court held that slaves were property, not persons for whom the Constitution provided due process protections assuring their personal liberty.¹⁰⁶ The Court also rejected the notion of popular sovereignty, which would have allowed the people in the territories of Kansas and Nebraska to determine by popular vote whether to adopt slavery.¹⁰⁷ Notably, seven of the nine *Dred Scott* justices were appointed by proslavery Southern presidents, and five of those seven presently owned or had previously owned slaves in Southern slaveholding states.¹⁰⁸ Chief Justice Roger Brooke Taney, in what has been described by Stuart Striechler as “one of the most prominent examples of judicial overreaching in the Supreme Court’s history,” concluded that at the time the Constitution was drafted, African Americans were not considered citizens, and were therefore denied access to the federal court system.¹⁰⁹ Moreover, Congress never held the power

98. *Id.* at 22–24.

99. FONER, *supra* note 93, at 22–24.

100. Wilmot Proviso of 1846.

101. *Id.*

102. *Id.*

103. *Prigg v. Pennsylvania*, 41 U.S. 539 (1842).

104. *Id.* at 540; *Ableman v. Booth*, 62 U.S. 506, 536 (1858).

105. *Scott v. Sandford*, 60 U.S. 393, 395–96 (1856).

106. *Id.* at 407.

107. *Id.* at 396.

108. VARON, *supra* note 46, at 296.

109. *Id.* at 297.

to exclude slavery from the states. And, in a tortured reading of the Fifth Amendment, Taney found that the rights of slaveholders to transport their slaves into the territories were protected due process and just compensation rights.¹¹⁰ Popular reaction favored the abolitionists' concerns that Northerners had lost political power over the protection of the Union and that free men had much to fear from encroachment by slaveholders.

Lincoln's run for the presidency in the election of 1860, in which he received 54% of the popular vote, was based on the Republican Party promise to make "no further extension of slavery into the territories."¹¹¹ His opponent, Stephen Douglas, ran as a Democrat on a platform of popular sovereignty.¹¹² But the Democrats were unable to reach policy consensus on slavery in the territories and Southern Democrats advocated for adherence to the Court's views in the *Dred Scott* decision.¹¹³ Two other opponents, John Breckinridge and John Bell, advocated for a reversal of the *Dred Scott* decision and more faithful adherence to the constitutional separation of powers.¹¹⁴

In 1860, seven Southern states (South Carolina, Georgia, Florida, Alabama, Mississippi, Louisiana, and Texas) attempted to secede from the United States in protest over President Lincoln's position on slavery.¹¹⁵ Shortly after he assumed the presidency, Lincoln was confronted with a demand from Southern states that he abandon the containment strategy and allow Southern slaveholders to participate in the settlement and development of the West, using slave labor to establish a competitive economic base. He rejected these demands and declared the ensuing acts of secession to be illegal. Yet, the secessionists manipulated the delegate vote at the state secession conventions and, despite lack of majority support for withdrawal from the Union, successfully avoided a popular vote which surely would have defeated the secession actions.¹¹⁶ Thus, most Southerners opposed secession and most Northerners were opposed to civil war. Northern business interests pressured Lincoln to forcibly maintain the Union. Lincoln simultaneously rejected the creation of the Confederate States of America on February 4, 1861, as well as its constitution, declaring that the federal government retains all rights in the purported "confederacy."¹¹⁷

The Civil War was a costly battle fought over national sovereignty and the preservation of slavery. Slavery's proponents advanced constitutional property

110. *Id.* at 298.

111. WILLIAMS, *supra* note 90, at 29.

112. *Id.* at 28.

113. *Id.*

114. *Id.*

115. *Id.* at 37.

116. MITCHELL, *supra* note 46, at 15.

117. *Id.*

interests and the sovereign interests of the individual states to be free from federal interference in commercial matters. South Carolina was the first of the Southern states to act upon its conviction that the Northern states were gaining the upper hand with regard to the preservation of the economic and cultural interests of the South. At the Charleston, South Carolina convention in December of 1860, the state legislature voted to dissolve the union between the state of South Carolina and the other states upon a determination that the compact between the federal government and the slaveholding states was broken when the Northern states refused to enforce the Fugitive Slave Act of 1850.¹¹⁸ In March of 1862, Congress made it illegal for United States soldiers to assist in the repatriation of slaves to their owners under the Fugitive Slave Act, adding to Southern concerns that Northern state influence was consolidating power and wealth within the emerging class of Northern capitalists.¹¹⁹

The Southern states' interpretation of the Constitution as nothing more than a contract among the states that could be broken by any single state's rejection of federal law provided the legal predicate for secession of the Southern states. This broken federal compact for the protection of the property interests of citizens of all states was their justification for seceding from the Union and forming their own confederacy of like-minded states. As noted by Georgia secessionist, Senator Robert Toombs, in his famous speech to the Georgia legislature on November 13, 1860, "we must expand or perish."¹²⁰

The ability of the Confederacy to wage an effective war was compromised by a lack of Southern unity of purpose and misguided efforts to recruit and maintain a fighting force. In April of 1862, the Confederate Congress passed a general conscription law, the first in the history of the country.¹²¹ Under this act, slaveholders owning twenty or more slaves were exempt and wealthy Southerners were allowed to hire stand-ins or avoid military service altogether by paying a fee.¹²² Southern planters defied Confederacy export limits on cotton, designed to encourage the growth of food needed to sustain the troops and their families at home. Overproduction of tobacco and cotton during the war resulted in a severe food shortage throughout the South. As one Confederate soldier noted in a letter to his wife,

discontent is growing rapidly in the ranks and I fear that unless something is done . . . we will have no army. The laws that have been passed generally

118. *Id.* at 13.

119. *Id.* at 29.

120. *Id.* at 13.

121. WILLIAMS, *supra* note 90, at 3.

122. *Id.*

protect the rich, and the poor begin to say it is the rich man's war and the poor man's fight, and they will not stand it.¹²³

By the end of the war, Jefferson Davis conceded that two-thirds of the Confederate soldiers had deserted.¹²⁴ By 1864, Southern antiwar sentiment made it difficult, if not impossible, to perpetuate the conflict. The Confederacy was defeated because its army was outnumbered on the battlefields and because of its inability to overcome disunity and rebellion throughout the South.

For President Lincoln and the majority of Northerners, abolition of slavery was not the goal of the war. Their strategy was one of containment of slavery for the larger good of the economic development of the West. The Free-Soil movement that arose during this time proved to be an effective rallying point against the expansion of slavery.¹²⁵ Its premise was that the expansion of slavery threatened the independence and economic prosperity of white Americans because it forced small and family farms to compete against wealthier slaveholders for land and market share in the new territories.¹²⁶ The message resonated with those seeking upward mobility, a traditionally Republican ideal of that era.¹²⁷ It also held great appeal for urban residents who were seeking cheap land that could be developed without competition from slave labor. In fact, however, after the conclusion of the Civil War, nine out of every ten acres sold under the Homestead Act were developed by speculators, rather than independent farmers.¹²⁸

During the war, President Lincoln issued the Emancipation Proclamation, leading to passage of the Thirteenth Amendment by Congress and its ratification by the states on December 6, 1865.¹²⁹ The Thirteenth Amendment freed the slaves and included an enabling provision which explicitly gave Congress "power to enforce this article by appropriate legislation."¹³⁰

While the Civil War raged, President Lincoln ran for reelection in 1864 against John C. Fremont, the nominee of the Radical Democratic Party.¹³¹ Lincoln's Republican Party developed a platform that included promises of national emancipation of slaves, equal civil rights for African Americans, and confiscation of the land claimed by the Confederacy.¹³² Fremont withdrew and

123. DAVID WILLIAMS ET AL., *PLAIN FOLK IN A RICH MAN'S WAR* 5 (2002).

124. *Id.*

125. MITCHELL, *supra* note 46, at 9.

126. *Id.*

127. *Id.*

128. *Id.* at 31.

129. *Id.* at 28.

130. U.S. CONST. amend. XIII, § 2.

131. *Elections from 1832-1872*, VA. HISTORICAL SOC'Y, <http://www.vahistorical.org/collections-and-resources/virginia-history-explorer-old/getting-message-out-presidential-campaign-0>.

132. *Id.*

was replaced in the campaign by General George B. McClellan, who opposed emancipation of the slaves.¹³³ Lincoln and his running mate, Andrew Johnson (a Southern Democrat who presided over reconstruction efforts after President Lincoln was assassinated), won the election with 55% of the popular vote.¹³⁴ By this point, the Confederate army was losing to the Union army and suffering mass defections of soldiers due to its inability to pay and provision its forces.¹³⁵ Military efforts to prevent the advance of the Union army through the South declined.¹³⁶ Beginning with the April 9, 1865 surrender of General Lee and his Army of Northern Virginia to General Sherman at Appomattox, and concluding with the delivery of the *CSS Shenandoah* to the British in Liverpool, England on November 11, 1865, the Southern Confederacy was defeated.¹³⁷

But the Confederate defeat did not restore the Union, nor did it end the nation's conflict over slavery. Frederick Douglass, in a speech delivered on May 10, 1865, entitled "The Need for Continuing Anti-Slavery Work," noted that the war provided a "highly instructive disclosure . . . of the true source of danger to republican government," which he identified as inequality, the root cause of slavery.¹³⁸ He further observed that "no republic is safe that tolerates a privileged class, or denies to any of its citizens equal rights and equal means to maintain them."¹³⁹ He was, of course, referring to the Thirteenth Amendment and the opportunity of freed slaves to participate in the electoral process.

Reconstruction efforts began long before Lee's surrender at Appomattox. President Lincoln carefully constructed a harmonizing political position that secession was unconstitutional and accordingly, the seceding states never actually left the Union. However, that did not resolve the issue of the relationship between the citizens of the states and the federal government. As the Reconstruction effort and more recent events have demonstrated, many of the same economic, class, and philosophical issues that divided our nation during the Civil War era influence political and constitutional debate today. We continue to debate the virtues of economic modernization and expansion within the context of very different visions of the noblest social order.

133. *Id.*

134. *Reelection*, ABRAHAM LINCOLN HISTORICAL SOCIETY, <http://www.abraham-lincoln-history.org/reelection/>.

135. Andrew F. Smith, *Did Hunger Defeat the Confederacy?*, 13 N. & S. 45, 46 (2011), available at <http://andrewsmith.com/wp-content/themes/wooden-mannequin/pdf/HungerArticle.pdf>.

136. *End of the War*, MERSEYSIDE MAR. MUSEUM, <http://www.liverpoolmuseums.org.uk/maritime/collections/americancivilwar/end-of-war.aspx>.

137. *Id.*

138. VARON, *supra* note 46, at 346.

139. *Id.*

V. RECONSTRUCTION AND NATIONALISM

The Civil War of 1861–1865, and the Reconstruction period which followed from 1865–1877, are generally acknowledged to have answered and put to rest the question of whether the Union was a voluntary pact among the states or a perpetual, constitutionally established and protected nation of states. Yet, achievement of American reunification required significant compromise and time to overcome lingering enmity and resolve conflicting interpretations over the reasons for the war. As noted by author Susan-Mary Grant, the Civil War “preserved the nation and made it both better and stronger than it had been before. . . . The emancipation of the slaves had been accomplished and consolidated in important amendments to the Constitution.”¹⁴⁰ The validity of the American experience in democratic government had been established. As Lincoln had hoped, the federal government proved to the world “that those who can fairly carry an election, can also suppress a rebellion—that ballots are the rightful and peaceful successors of bullets; and that when ballots have fairly and constitutionally decided, there can be no successful appeal back to bullets.”¹⁴¹

While the Civil War resolved the issue of nationalism in the broad context of the Southern separatist movement and the nation was preserved, the reconciliation process required compromise, accommodation, and patience. Southern states rejected congressional versions of Reconstruction which were seen as retribution by Northern states. There was tremendous social upheaval caused by the emancipation of five million slaves. Where Lincoln proposed Reconstruction plans that included pardons and recognition of state governments in which at least 10% of eligible voters pledged an oath of loyalty to the Union, Republicans in Congress sought to impose more stringent conditions upon the reunification of Southern states.¹⁴² Congress refused to seat senators and representatives elected by Arkansas, Louisiana, Virginia, and Tennessee, the four states whose governments Lincoln had previously recognized.¹⁴³ It passed the Wade-Davis Bill, setting its own conditions for recognizing the readmission of Confederate states.¹⁴⁴ The authority of Congress to determine the terms of Reconstruction became a Republican platform issue in the election of 1864 and Lincoln was required to take a more flexible position to secure his reelection.¹⁴⁵

140. SUSAN-MARY GRANT, *NORTH OVER SOUTH: NORTHERN NATIONALISM AND AMERICAN IDENTITY IN THE ANTEBELLUM ERA* 171 (2000).

141. *Id.*

142. FORREST McDONALD, *STATES' RIGHTS AND THE UNION* 209 (2000).

143. *Id.*

144. *Id.*

145. *Id.*

Lingering economic disparities complicated the reunification of the South. Emancipated slaves and poor whites endured political and economic oppression. Small farmers lost their land to creditors during the war and were forced into sharecropping and tenancy relationships with the landholders. Urban workers were paid in scrip, not cash, and subject to disadvantageous credit policies dictated by company stores in company towns. The Populist Party sought to unite oppressed blacks and whites in both rural and urban areas of the country. All the while, the Southern plantation owners reestablished their economic and political dominance over Southern state governments. Jim Crow laws were enacted, embedding racial segregation as the new social order in the South. Essentially, the cotton agricultural economy of the South controlled by the wealthy plantation owners survived the conflict with very little change. Significant change would not come until much later, once the New Deal programs and civil rights movement forced federally mandated economic and educational inclusion of the disenfranchised.

Perhaps the most significant legacy of the period of the Civil War and Reconstruction is an acceptance of the Supreme Court as the final arbiter of constitutional issues. This view rejected the long-held views of Thomas Jefferson, who espoused coequal constitutional authority by the three branches of government, giving greater overall authority to the elected politicians. It also rejected the belief that the states were empowered to exercise a vote of nullification in avoidance of unpopular federal legislation. The prevailing view was that states were allowed to exercise police power over matters involving health, property, public safety, education, and religion under the powers reserved to them under the Constitution. And, therefore, to the extent that federal actions infringed upon the autonomy of the states, the rights of the states were protected. These protected state interests came under new scrutiny beginning in the 1930s, in connection with the Court's review of legislation directed towards combatting the effects of the Great Depression. The economic measures adopted under President Roosevelt's New Deal were largely unchallenged until the Supreme Court considered *A.L.A. Schechter Poultry Corp. v. United States*,¹⁴⁶ in which it held that New Deal wage and hour laws had merely an indirect effect on interstate commerce and therefore, Congress exceeded its authority to legislate in that area of commerce.

Roosevelt was reelected by a landslide vote and, not having forgotten the Court's efforts to thwart his New Deal agenda, he immediately threatened to replace members of the Court with judges favoring his political agenda.¹⁴⁷ Although his threat was abandoned, it achieved its intended effect, causing sitting justices to modify their positions while others were replaced with men who leaned more favorably towards Roosevelt's views on the scope of federal

146. *A.L.A. Schechter Poultry Corp. v. United States*, 295 U.S. 495, 550 (1935).

147. MCDONALD, *supra* note 142, at 228–29.

constitutional authority.¹⁴⁸ During the ensuing twenty years, the Court exhibited remarkable judicial restraint, holding exactly one act of Congress and one executive order unconstitutional.¹⁴⁹

The Roosevelt Court decided *Wickard v. Filburn*,¹⁵⁰ finding that Congress is broadly empowered by the commerce clause to regulate a farmer's decision to grow wheat for personal or family consumption because the collective action of farmers to exclude their produce from the market has an effect on commerce. The *Filburn* case would later feature prominently in the legal debate over congressional authority to require individuals to participate in the health insurance market once they had elected to exempt themselves from that activity.¹⁵¹

Under the presidency of Lyndon Baines Johnson, state exercise of police powers became increasingly federalized under the threat of loss of federal funding.¹⁵² As the power of the federal government grew, the balance of spending shifted dramatically from state and local governments to the federal government.¹⁵³ Concerns over the dramatic increase in federal spending drove accountability studies, producing evidence of \$400 hammers and special interest "bridges to nowhere."¹⁵⁴ State governors began to explore innovative programs to solve their own problems and minimize dependency on federal financing.¹⁵⁵ Most state legislatures mandated balanced budgets and state politicians were forced to compromise and publicly account for state spending.¹⁵⁶ Public perception of the effectiveness of state government improved and the public was able to readily hold local politicians accountable for the decisions made with regard to spending, taxation, and economic development. As the composition of the Supreme Court became more conservative, states rights reemerged as a powerful constitutional limitation of the exercise of congressional authority, particularly with regard to matters of commerce.¹⁵⁷

148. *Id.* at 229.

149. *Id.*

150. *Wickard v. Filburn*, 317 U.S. 111, 124 (1942).

151. James Stewart, *How Broccoli Landed on Supreme Court Menu*, N.Y. TIMES, June 13, 2012, http://www.nytimes.com/2012/06/14/business/how-broccoli-became-a-symbol-in-the-health-care-debate.html?pagewanted=all&_r=0.

152. MCDONALD, *supra* note 142, at 231.

153. *Id.*

154. *Id.*

155. *Id.* at 231–32.

156. *Id.* at 232.

157. *Id.*

VI. STATES' RIGHTS, THE COMMERCE CLAUSE, AND DUAL FEDERALISM

Under the general welfare clause, Congress has been permitted to tax and spend for any purpose, and Article I, Section 8 historically was not viewed as a constraint on its power to place conditions on the receipt of benefits.¹⁵⁸ This view of the commerce clause allowed congressional incursion into areas typically reserved to the states, such as race relations, setting a minimum age for drinking, access to unemployment benefits, highway safety, public education, and even medical care.¹⁵⁹ More recently, however, culturally controversial conduct such as partial-birth abortions, immigration policy, and gun control has led to a reconsideration of the role of the federal government in resolving such issues.¹⁶⁰ In a resurgence of notions of dual federalism, dominant political powers both at the state and federal levels have attempted to claim exclusive government authority over matters involving morality and differing ideology.¹⁶¹ Moreover, Calhoun's compact theory of union is enjoying a bit of resurgence in connection with state reaction to the enactment of the Affordable Care Act.¹⁶² Calhoun's theory, adopted by the Antifederalists, viewed the United States as a contractual union of sovereign states.¹⁶³ But, the Civil War effectively jettisoned the nullification remedy as an effective and appropriate state response to conflicting federal interests.¹⁶⁴

States' rights supporters argue for narrow national power and, as Sotirios Barber notes, states' rights federalism is a normative position, rightly perceived as part of a broader theory of the correct way to conduct the affairs of the nation.¹⁶⁵ As such and when applied to matters of commerce, states' rights supporters would argue that where different communities apply different definitions of prosperity, self-determination requires that each community permits the others to define and pursue prosperity as a matter of liberty and self-determination.¹⁶⁶ Federalism recognizes that the powers of the federal government are limited by the enumerated powers set forth in Article I, Section 8, the Civil War Amendments, and the Nineteenth Amendment.¹⁶⁷ And, until the recent Supreme Court decision on health care reform which imposed new constraints, the general welfare clause permits Congress to tax and spend for essentially any purpose.¹⁶⁸ And with regard to the Civil War Amendments,

158. SOTIRIOS A. BARBER, *THE FALLACIES OF STATES' RIGHTS* 164 (2013).

159. *Id.*

160. *Id.* at 165.

161. *Id.*

162. *Id.* at 94.

163. *Id.* at 130.

164. BARBER, *supra* note 158, at 136–37.

165. *Id.* at 123.

166. *Id.* at 123–24.

167. *Id.* at 103.

168. *Steward Mach. Co. v. Davis*, 301 U.S. 548, 581 (1937).

Barber asserts that no meaningful line has ever separated security and economic concerns from moral concerns, whether those concerns originate publicly or privately.¹⁶⁹ He further observes that actions cannot be separated into those undertaken for purely economic reasons and those that have a noneconomic purpose because individual moral and religious beliefs define their definitions of what “living well” and “doing good” mean, and people generally strive to live well and do good.¹⁷⁰

VII. THE POLITICS OF HEALTH CARE

The regulation of health care delivery has typically fallen within the purview of the police power of the states.¹⁷¹ Yet, in reality, this has been an area of dual control by the federal and state governments, dating back to legislation in 1798 that established US Marine hospital services, providing medical care for sailors.¹⁷² Over the next two hundred years, Congress expanded and reinforced its role through enactment of social and regulatory legislation controlling the manufacture, distribution, and pricing of pharmaceuticals, expanding access to needed health care services for large categories of Americans, and many other measures affecting the provision of health care service in the United States. The rights of state governments to enact laws regulating the practice of medicine, make provision for charity medical care, and generally oversee the business of health care companies were acknowledged as early as 1842 in *Gibbons v. Ogden*.¹⁷³

The regulation of public health, safety and welfare, and morals falls within the powers reserved to states under the Constitution. States have assumed regulatory control over the delivery of health care services within their boundaries through licensure of health care providers and regulation of the quality and safety of the services they deliver. As observed during the early Ebola virus cases in America in 2014, state governments establish quarantine rules as part of their regulation of public health. States provide community health centers and mental and substance-abuse services directly to citizens.¹⁷⁴

169. BARBER, *supra* note 153, at 168.

170. *Id.*

171. MCDONALD, *supra* note 142, at 115–16.

172. Rick Ungar, *Congress Passes Socialized Medicine and Mandates Health Insurance- In 1798*, FORBES, Jan. 17, 2011, <http://www.forbes.com/sites/rickungar/2011/01/17/congress-passes-socialized-medicine-and-mandates-health-insurance-in-1798/>.

173. See *Gibbons v. Ogden*, 22 U.S. 1 (1824); *United States v. S. E. Underwriters Ass'n*, 322 U.S. 533 (1944).

174. Joel E. Miller, *Too Significant to Fail: The Importance of State Behavioral Health Agencies in the Daily Lives of Americans with Mental Illness, Their Families, and Their Communities*, NAT'L ASS'N STATE MENTAL HEALTH DIRECTORS (2012), available at <http://www.nasmhpd.org/docs/publications/Too%20Significant%20To%20Fail.pdf>.

Over the years, the regulation of the markets for insurance products has shifted. In 1944, the Supreme Court extended the authority of Congress under the commerce clause to regulate health insurance markets.¹⁷⁵ The following year, at the behest of the insurance industry and concerned state insurance regulators who strongly preferred state regulatory oversight, Congress enacted the McCarran-Ferguson Act.¹⁷⁶ This permitted states to resume the regulation of health and other types of insurance under a reverse-preemption scheme that exempts state laws regulating the business of insurance from federal preemption.

Otherwise, the federal and state governments have exercised shared responsibility over matters involving access and delivery of health care, often times with the federal government advancing broad policy objectives and the states responding with supportive legislation. Congress has placed substantial restrictions on financial relationships within medical markets,¹⁷⁷ imposed national standards on the privacy and security of health information,¹⁷⁸ and directed all hospitals receiving Medicare payments to provide stabilizing care for indigent patients without regard to their ability to pay.¹⁷⁹ State legislatures have established regulatory schemes over medical liability and relationships among health care professionals and payers, while protecting markets through licensure and oversight of all classes of participants.

Notably, with regard to comprehensive plans to broaden access or subsidize payment, candidates for presidential office often stepped out in front of Congress and the broader debate over responsibility for providing access to health care services. In 1912, Theodore Roosevelt's Progressive Party platform included a proposal for a national health insurance program. In President Franklin D. Roosevelt's 1944 State of the Union speech, he articulated a desire for a second bill of rights assuring the right of every American to "adequate medical care and the opportunity to achieve and enjoy good health."¹⁸⁰ President Roosevelt's New Deal legislation included the Social Security Act, which has served as a foundation for introducing and expanding health benefits to specified categories of needy Americans ever since.¹⁸¹

In 1945, President Harry S. Truman, building upon his Democratic predecessors' vision, became the first United States president to propose a

175. *See S. E. Underwriters Ass'n*, 322 U.S. at 533–95.

176. McCarran-Ferguson Act, 15 U.S.C. § 1011 (2012).

177. *See, e.g.*, Physician Self-Referral Act, 42 U.S.C. §1395nn (2012); Medicare Anti-Kickback Statute, 42 U.S.C. § 1320a-7b (2012); Civil Monetary Penalties Act, 42 U.S.C. § 1320a-7a.

178. Health Insurance Portability and Accountability Act, Pub. L. No. 104-191 (1996).

179. Emergency Medical Treatment and Active Labor Act, 42 U.S.C. §1395dd (1986).

180. Benjamin Mason Meier, *Health Care as a Human Right*, in DEBATES ON U.S. HEALTH CARE 32, 37 (Jennie J. Kronenfeld et al. eds., 2012).

181. *Id.*

national health insurance plan using the social security system as the platform.¹⁸² His vision reflected the internationally prevalent view that everyone “has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing, medical care, and necessary social services.”¹⁸³

President John F. Kennedy was keenly interested in providing federal health care assistance to elderly Americans. He was unable to complete his work in that area and his successor, President Lyndon B. Johnson, became the first president to successfully implement broad federal government health care reform. He did so over the strenuous objections of the Republicans in Congress and the health care delivery system itself, particularly the American Medical Association. In 1965, Congress enacted the Medicare and Medicaid programs as 1966 amendments to Titles XVIII and XIX, respectively, of the Social Security Act.¹⁸⁴ The Medicare program is a federal insurance program providing coverage for persons who are sixty-five, blind, disabled, or suffer from end stage renal disease or Lou Gehrig’s disease. It consists of several different parts, divided into programs, some of which involve voluntary enrollment and enrollee payment contributions. Medicare Part A pays for inpatient hospital care, inpatient skilled-nursing care, home health care, and hospice care.¹⁸⁵ Medicare Part B, otherwise known as supplemental medical insurance, covers physician services, physical therapy, laboratory, and diagnostic services.¹⁸⁶ All Medicare-eligible individuals are enrolled in Part A.¹⁸⁷ Participation in the other parts of the Medicare program are elective.¹⁸⁸ Virtually all nonworking, eligible Americans are enrolled in Medicare Part A.¹⁸⁹

The Medicaid program is also a form of public health insurance, provided not by the federal government, but rather by state health plans, and financed jointly by federal grants and state budget monies.¹⁹⁰ Each state plan establishes its own eligibility criteria, scope of covered services, provider reimbursement schedules, and administrative services, all subject to program goals and

182. *Id.*

183. Universal Declaration of Human Rights, G.A. Res. 217 (III) A, U.N. Doc. A/RES/217(III) (Dec. 10, 1948).

184. 42 U.S.C. §§1395-1395ccc; 42 U.S.C. §§1396-1396v.

185. HENRY J. KAISER FAMILY FOUND., A PRIMER ON MEDICARE: KEY FACTS ABOUT THE MEDICARE PROGRAM AND THE PEOPLE IT COVERS 1 (2015), available at <http://kff.org/medicare/report/a-primer-on-medicare-key-facts-about-the-medicare-program-and-the-people-it-covers/>.

186. *Id.* at 1, 5.

187. *Id.* at 2.

188. *Id.*

189. *Id.*

190. HENRY J. KAISER FAMILY FOUND., MEDICAID MOVING FORWARD (2015), available at <http://kff.org/medicaid/fact-sheet/the-medicaid-program-at-a-glance-update/>.

restrictions imposed by the federal government. Receipt of federal Medicaid funds is conditioned on each state's voluntary participation, and all states currently participate in the Medicaid program.¹⁹¹ These two programs have expanded considerably over the years, and today provide health insurance to millions of beneficiaries. Expansion of the Medicaid program typically impacts state budgets because the federal government is committed to pay no more than 50% of the total national cost, leaving states to finance the balance, the percentage of which varies by state based on the application of the federal matching formula under which these funds are allocated.¹⁹²

The Medicare and Medicaid programs provide coverage to eligible categories of elderly, disabled, and poor individuals. For those who do not fall within these protected groups, access to health care has always been a function of one's ability to acquire services either through private insurance, other public programs such as those covering government employees or veterans and their families, employer-sponsored health plans, or through charity care. As the cost of health care rose in relation to American GDP beginning in the 1970s, more Americans have been excluded from the insurance markets by virtue of cost and poor health status. In 1971, Senator Ted Kennedy (D-MA) introduced the Health Security Act, which, if enacted, would have created a single-payer, government-sponsored health plan in which all Americans would participate.¹⁹³ Senator Kennedy viewed health care as a human right that required protection from the federal government.

Not everyone views access to necessary health care services as a human right. Indeed, Republican presidents who followed took a more conservative approach to health care, consistent with their belief that health care was more of a responsibility than a right. This philosophical perspective, advanced by President Richard Nixon, favored expansion of employer-sponsored private health insurance, while continuing Medicaid-sponsored benefits for the indigent. In 1971, he implemented federal wage and price controls, which, as applied to the health sector of the economy, caused a decline in short-term

191. NAT'L CONFERENCE OF STATE LEGISLATURES, MEDICAID (2013), *available at* <http://www.ncsl.org/research/health/medicaid-home-page.aspx>; CTR. ON BUDGET & POLICY PRIORITIES, POLICY BASICS: INTRODUCTION TO MEDICAID (2013), *available at* <http://www.cbpp.org/cms/index.cfm?fa=view&id=2223>.

192. VICTORIA WACHINO ET AL., HENRY J. KAISER FAMILY FOUND., FINANCING THE MEDICAID PROGRAM: THE MANY ROLES OF FEDERAL AND STATE MATCHING FUNDS (2004), *available at* <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/financing-the-medicaid-program-the-many-roles-of-federal-and-state-matching-funds-policy-brief.pdf>.

193. Jennifer Evans & Jaclyn Shiff, *A Timeline of Kennedy's Health Care Achievements and Disappointments*, Kaiser Health News, Sept. 17, 2010, <http://kaiserhealthnews.org/news/kennedy-health-care-timeline/>.

spending, and the pressure to address the affordability of health care waned.¹⁹⁴ In 1975, the price controls were lifted and prices throughout the health care economy began to surge.¹⁹⁵

President James Carter identified health care cost control as a priority of his domestic policy. His first legislative initiative was directed towards controlling inpatient hospital costs. As has often been the case over time when threatened with expanded federal regulation, the health care system—in this instance, the hospitals—responded with their own set of cost-reducing initiatives.¹⁹⁶ Congress defeated the proposed legislation. In 1983, President Ronald Reagan introduced a major effort to constrain the cost of hospital services. Up until that time, the government and many private payers reimbursed hospitals on the basis of audited costs allowed under contractually specified reimbursement formulas. The Medicare program, in a change replicated by private health insurers, replaced the cost-based reimbursement system with one that rewarded hospitals for more efficient, and therefore presumptively lower-cost, treatment of patients.¹⁹⁷ Hospitals continue to be reimbursed for inpatient services under a Diagnosis-Related Group (DRG) formula, which estimates an average length of an inpatient stay for patients with like diagnoses and pays the hospital at that rate, regardless of the patient's actual length of hospitalization.¹⁹⁸ The move away from cost-based payment methodologies represents the first of many national regulatory interventions on health services markets tied to the provision on federally financed health care.

By the time President Reagan took office, fiscal conservatives were firmly in control and little thought was given to expanding federal government sponsorship of improved access to health care services. Despite the savings in hospital payments under the DRG formula, overall spending increased, along with 5.5% per capita spending increases in other areas of the health care economy.¹⁹⁹ During the 1992 presidential race, candidate William Clinton promised to reform a health care system that “leaves 60 million Americans without adequate health insurance, bankrupts families, businesses, and the federal budget.”²⁰⁰

194. Karen Davis & Kristof Stremikis, *The Costs of Failure: Economic Consequences of Failure to Enact Nixon, Carter, and Clinton Health Reforms*, Commonwealth Fund Blog, Dec. 21, 2009, <http://www.commonwealthfund.org/publications/blog/the-costs-of-failure>.

195. *Id.*

196. Daniel Beland & Alex Wadden, *Health Politics and the Patient Protection and Affordable Care Act*, in *ISSUES IN AMERICAN POLITICS: POLARIZED POLITICS IN THE AGE OF OBAMA* 44, 46 (John Dumbrell ed., 2013).

197. *Id.*

198. *Id.*

199. *Id.*

200. *Id.*

In 1994, President Clinton proposed the ambitious and comprehensive Health Security Act, a universal coverage plan with incremental, market-based changes.²⁰¹ His proposed legislation was rejected by both Democrats who favored a rights-based, single-payer plan and Republicans who were opposed to government intrusion into private health insurance markets. Congress overwhelmingly rejected the proposed legislation as too complex and radical. Although health care costs moderated during the debate over Clinton's Health Security Act, presumably due to health care provider self-imposed moderation in the volume of services delivered, other factors quickly produced a reversion to historic utilization levels.²⁰² Notably, in an effort led by physicians and patients, there was widespread private-sector objection to the effects of managed care products that required prior approval from health plan medical administrators before services would be covered.²⁰³ On the one hand, these products offered significantly lower premium costs due to their tight administration of the utilization of services; on the other hand, the denial of prescribed and ordered services challenged the independence of treating physicians and limited treatment options for patients.

President George W. Bush, a Republican, is credited with a significant and popular expansion in the scope and delivery of Medicare program benefits. The Medicare Modernization Act of 2003 added a new Medicare benefit, Part D, providing beneficiaries access to a voluntary prescription drug benefit.²⁰⁴ Further amendment to the Social Security Act enlarged the role of private insurers by creating the Medicare Advantage program, a risk-based partnership between the federal government and private insurers to finance and deliver Medicare Parts A, B, and D coverage through a delivery model built upon the Medicare Part C managed care platform.²⁰⁵ Approved Medicare Advantage (MA) plans compete against each other and against the voluntary Medicare supplemental insurance market by offering regional HMO-like Medicare benefit plans that combine the hospitalization, medical care, and drug benefits into a single, subsidized monthly premium paid by consumers who choose that option over traditional Medicare coverage.²⁰⁶ The Centers for Medicare & Medicaid Services administers the Medicare Advantage program, as well as traditional Medicare benefits, and reimburses the MA insurers and HMOs for Part A services on a capitated basis. Beneficiary premiums cover the majority of the service costs of Parts B and D.²⁰⁷ MA plans compete for approval to

201. *Id.*

202. Beland & Wadden, *supra* note 196, at 46.

203. *Id.*

204. HENRY J. KAISER FAMILY FOUND., *supra* note 185, at 1.

205. *Id.* at 1, 6.

206. *Id.* at 9, 12.

207. *Id.* at 10.

offer products based on periodic bidding related to premium cost and benefit design, both of which are subject to extensive regulatory oversight.²⁰⁸

In 2008, the Democratic Party chose to include health care reform as a major element of its national platform. Hillary Clinton was contesting Senator Barack Obama for the nomination, and inevitably, the Clinton presidency's failed Health Security Act assumed a prominent role in the public posturing of the candidates leading to the party's selection of Senator Obama as its presidential candidate. Senator Obama ran against Senator John McCain, who was joined on the Republican ticket by former Alaskan governor and Tea Party advocate Sarah Palin.

Senator McCain clearly articulated the Republican Party perspectives on access to health care during the second presidential debate when he described health care as a responsibility, not a right, while rejecting a government coverage mandate as inimical to an individual's right to liberty and freedom from government intrusion. Senator Obama offered a very different view on health care reform as originating more like a moral commitment and economic imperative than a privilege or matter of individual responsibility.²⁰⁹ These philosophical differences bear further consideration as they reflect the two prevalent views informing the political debate on health care reform in modern America. They also influence judicial determinations based on constitutional challenges to the Affordable Care Act.

At base level, access to health care is a debate centered on whether health care itself is a commodity or a basic human need. If viewed as a human right derived from a basic need, it would be available to everyone regardless of health status or ability to pay. When viewed as a privilege, the implication is that it is a commodity available to those who have the means to purchase health care, the price of which would be reflective of the risk of providing coverage to that individual.²¹⁰ Accordingly, despite a desire to acquire access to health care, if you are without the means to pay the premium, you are excluded from that market. This occurs, in part, due to the unique attributes of the market for health insurance. Unlike other commodity markets, in which sellers compete for sales based on quality and price, health insurers are largely insulated from such competitive pressures. Through permissive regulation, insurers in the individual and small-group product markets systematically address high cost risks through a medical underwriting process that considers and rejects the least desirable individuals, while increasing premium rating factors for those accepted risks who evidence significant prior contacts with

208. *See generally id.*

209. Meier, *supra* note 180, at 34.

210. ANDREW KOPPELMAN, THE TOUGH LUCK CONSTITUTION AND THE ASSAULT ON HEALTH CARE REFORM 5 (2013).

the health care delivery system.²¹¹ This risk-rating system is directed towards an industry-wide goal of assuring that premiums collected for their insurance products will exceed the cost of claims plus administrative overhead. Risk evaluation and management is the *sine qua non* of insurance. Without careful evaluation and pricing of risk, insurers compromise the financial viability of their products and ultimately, the solvency of their enterprise. This market functions very differently from social insurance programs in which risk is not a relevant factor. Indeed, our most prominent social health insurance programs, Medicare and Medicaid, provide broad coverage to high-risk patient populations for whom private insurance would be financially unattainable, or more likely, unavailable.

Is there an ethical obligation to provide timely health care access because, eventually, all members of our society will be subject to illness and death, regardless of their best efforts to prevent illness and disease? Does the inevitability of illness and death impact individuals differently based on opportunity? Does lack of access to health insurance make people unhealthy or hasten their death? And what is the role of government in responding to these issues?

Some of these questions may be answered by reference to scientific data,²¹² others involve matters of opinion, religious and moral belief, and philosophy. Regardless of the source, American opinion is varied and passionately advanced. On the one hand, many believe the social determinates of health, such as income inequality, access to education and employment, and family structure, to be primary causative and controllable factors. Accordingly, they would argue that health is not a special right and the government is not responsible for assuring protected access to health care for its citizens. This view is consistent with Libertarian ideology that defines human rights as natural rights enjoyed by individuals without imposing burdens on the rights of others. Natural rights, which include freedom of speech, belief, movement, and ownership of private property, are the hallmark of limited government. Conversely, non-natural rights are those provided by the government that all tend to encourage the expansion of the welfare state through taxation and the socialization of services.²¹³ The goal of Libertarians is individual liberty, achieved through operation of a market-based economy in which government mandates that infringe upon property interests can have no place. Mandates are

211. *Id.* at 4.

212. INST. OF MED., *supra* note 32, at 2. In 2002, the Institute of Medicine's Committee on the Consequences of Uninsurance released a study entitled *Care Without Coverage: Too little Too Late*, in which it surveyed 130 reported studies in the medical literature, concluding that for individuals between the ages of twenty-five and sixty-five who did not have health insurance, their age-adjusted rates of mortality were 25% higher than their insured counterparts. *Id.*

213. *Id.* at 42.

viewed as an involuntary redistribution of an individual's personal resources to benefit others. And, therefore, health care is a commodity, not a right, and the most efficient system for providing access to health care is competition through a free-market economy.²¹⁴ Libertarian views on individual liberty and health care conflict with international goals fostering equality of access through redistribution, while reflecting symmetry with the health care policy objectives of the Republican Party.

VIII. AMERICANS DRAW THE LINES ON HEALTH CARE

In a debate that has ebbed and flowed over time, Americans reengaged on the health care battleground during the 2008 and 2012 presidential campaigns. In the interim, of course, Congress passed the legislation known to Democrats as the Affordable Care Act, and reviled in all respects by Republicans, who immediately adopted the politically expedient replacement title, "ObamaCare." In a perversion of that famous quotation from William Shakespeare's *Romeo and Juliet*, the Republicans renamed the legislation so that the stink of the legislation would forever be linked to an increasingly challenged and unpopular president.²¹⁵ Ironically, Americans' confusion over the title has led to interesting public opinion polling data in which a majority of Americans dislike ObamaCare, while favoring the benefits received under the Affordable Care Act by a similar percentage point spread.²¹⁶

In the two decades preceding the Civil War, a competitive, two-party political system emerged in America. The electability of candidates advanced in a multiparty political system is a function of developing alliances that represent the broadest possible swath of Americans, while minimizing ideological differences rooted in religious beliefs, class, race, and geography. As noted by Marvin Meyers, distinctions among American political parties have been along lines of persuasion, not ideology.²¹⁷ Competing ideological perspectives on economic and social development are not conducive to political compromise. Then, as now, politicians were forced to confront and manage extreme ideological positions of individuals and groups working on the fringe of the political debate. During the antebellum period, abolitionists helped to shape Northern public opinion against slavery while simultaneously

214. See *Libertarian Party 2014 Platform*, LIBERTARIAN PARTY, <http://www.lp.org/platform> (last visited Nov. 8, 2014).

215. WILLIAM SHAKESPEARE, *ROMEO AND JULIET* act 2, sc. 2. The original quotation from the play: "O! Be some other name: What's in a name? That which we call a rose by any other name would smell as sweet."

216. HENRY J. KAISER FAMILY FOUND., KAISER HEALTH TRACKING POLL 3, 9 (2013), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/06/8451-t.pdf>.

217. MARVIN MEYERS, *THE JACKSONIAN PERSUASION: POLITICS AND BELIEF* 274 (1960).

precipitating the South's inevitable defense of the institution. As one of the leading Southern politicians of the day, John C. Calhoun, observed:

This agitation has produced one happy effect at least; it has compelled us in the South to look into the nature and character of this great institution, and to correct many false impressions that even we had entertained in relation to it. Many in the South once believed that it was a moral and political evil; that folly and delusion are gone; we see it now in its true light, and regard it as the most safe and stable basis for free institutions in the world.²¹⁸

The most radical abolitionists were dedicated towards driving slavery into every political debate. Politicians resisted but were ultimately forced to confront slavery within their broader positioning on democratic values, western development, free labor, and nationalism. The future of America was at stake.

Although there are many divisive issues characterizing modern American politics, none seems to have precipitated as much controversy and chaos as health care reform. Once the parameters for the legislation were established, the political debate was relatively abbreviated. That of course, is a major contributor to the public backlash: the minority party felt slighted in the congressional debate and frustrated by the majority party's successful imposition of procedural rules that largely confined debate to committee hearings and televised Sunday morning talk shows. The political constraints imposed on development of the legislation itself, which were necessary to achieve the Democrats' reform goal in a Congress characterized by hyperpartisanship, did little to curtail political rhetoric outside the chambers of Congress. As noted by Barbara Sinclair in her work, *Unorthodox Lawmaking: New Legislative Processes in the U.S. Congress*,²¹⁹ Democratic congressional leadership had to resort to "hyper-unorthodox" procedures to achieve comprehensive health care reform. Not only were the parties divided ideologically, religiously, economically, and morally on the need for health care reform, but the legislative process itself also generated frustration and resentment which survived the enactment of the reform bills. These same issues that informed the political strategy of those opposing reform now form the basis for a multiphasic challenge to the legislation, encompassing continued efforts to defeat the legislation through repeal, nullification, amendment, withdrawal of funding, and litigation.

National and state political party platforms have addressed health care policy issues over the past several election cycles. These statements provide insight into the delicate ideological balancing efforts necessary to maintain modern party unity. Like the politicians of the mid-1800s, both parties rely

218. FONER, *supra* note 93, at 41.

219. BARBARA SINCLAIR, *UNORTHODOX LAWMAKING: NEW LEGISLATIVE PROCESSES IN THE U.S. CONGRESS* 137 (2d ed. 2000).

upon individuals representing more extreme perspectives to inform, finance, and ultimately, influence public opinion as well the election of like-minded politicians. While the extremists have advanced their religious, moral, and economic vision for the future of America, mainstream politicians were able to focus on less divisive matters involving the economy and the budget. However, as the debate over health care reform illustrates, conservative extremists appropriated the national debate, impeding the politicians' preference to avoid engagement on the more controversial aspects of reform. As part of a concerted conservative effort to reject health care reform, opponents have strategically divided their efforts. Outside of the political arena, special interest groups have assumed an important role in the financing and pursuit of many of the legal challenges to the ACA. The Tea Party movement adopted health care reform as its platform for restoration of individual liberties and states' rights. In combination, fiscal conservatives, the religious right, Tea Party adherents, and modern Federalists have pressured the national and state Republican parties to pursue every means available to repeal President Obama's legacy legislation. The Democrats barely succeeded in achieving the requisite votes to pass the legislation and have struggled to meet public and political criticism regarding implementation problems and the cost of compliance imposed on Americans.

In its 2012 platform statement, the Democratic Party takes appropriate credit for the ACA, while acknowledging the maelstrom of opposition and the need to address its imperfections:

We believe accessible, affordable, high quality health care is part of the American promise, that Americans should have the security that comes with good health care, and that no one should go broke because they get sick. Over the determined opposition of Republicans, we enacted landmark reforms that are already helping millions of Americans, and more benefits will come soon.

As a result of our efforts, today, young Americans entering the workforce can stay on their parents' plans. Insurers can no longer refuse to cover kids with pre-existing medical conditions. Insurance companies will no longer be able to arbitrarily cap and cancel coverage, or charge women more simply because of their gender. People with private insurance are getting preventive services like cancer screenings, annual well-woman visits, and FDA-approved contraception with no out-of-pocket costs. We've established new Offices of Minority Health, and are helping state Medicaid programs fund home and community-based services. Small businesses are receiving tax credits to help them cover their workers, and businesses and families are receiving rebates from insurers who overcharged them.

Soon, working families will finally have the security of knowing they won't lose health care or be forced into bankruptcy if a family member gets sick or loses their job. And soon, insurance companies will no longer be able to deny coverage based on pre-existing conditions. Medicaid will cover more

working families. Those who don't get insurance at work will be able to shop in new exchanges and will be eligible for new tax credits. As a result, all Americans will have access to health care. We heard powerful testimony before the platform drafting committee about the difference it will make in Americans' lives when, for the first time, 30 million of our fellow citizens finally gain health insurance.

Mitt Romney and the Republican Party would repeal health reform. They are more concerned with playing politics than supporting families in this country. No law is perfect and Democrats stand willing to work with anyone to improve the law where necessary, but we are committed to moving forward. We will continue to stand up to Republicans working to take away the benefits and protections that are already helping millions of Americans every day. We refuse to go back to the days when health insurance companies had unchecked power to cancel your health policy, deny you coverage, or charge women more than men.

At the same time, the Affordable Care Act is not the end of efforts to improve health care for all Americans. Democrats will continue to fight for a strong health care workforce with an emphasis on primary care. We remain committed to eliminating disparities in health and will continue to make sure families have access to mental health and substance abuse services. We will strengthen Medicaid and oppose efforts to block grant the program, slash its funding, and leave millions more without health insurance.²²⁰

In juxtaposition, the Republican National Committee platform offers great insight and explanation for the party's issues with ObamaCare and its expansion of the Medicaid program to provide health care access to additional categories of eligible Americans. In the preamble, the party establishes:

We are the party of the Constitution, the solemn pact which confirms our God-given individual rights and assures that all Americans stand equal before the law. . . . We support efforts to help low-income individuals get a fair chance based on their potential and individual merit. . . . In a free society, the number one role of government is to protect the God-given, inalienable rights of its citizens, including the rights to life, liberty and the pursuit of happiness. Merit, aptitude and results should be the factors that determine advancement in our society.²²¹

The Republicans provide further support for their policies by including a recital of their views on federalism. In their party platform statement

220. 2012 *Democratic National Platform*, DEMOCRATIC PARTY, <http://www.democrats.org/democratic-national-platform#american-community> (last visited Mar. 24, 2015).

221. 2012 *Republican Platform*, REPUBLICAN PARTY, <https://gop.com/platform/we-the-people/> (last visited March 24, 2015).

supporting a smaller federal government, and citing the Ninth Amendment,²²² they call for a review and elimination of all federal agencies that engage in wasteful spending or abuse their power, noting that there are government functions that are best performed by state governments as the instruments of self-governance on behalf of individuals' rights. In a rather extreme expression of the value of limited federal government, the Republican 2012 policy statement refers to entrenched federal public programs that take money away from the states, "laundering it" through various federal agencies, only to return to the states "shrunk grants with mandates attached."²²³ The Medicaid program likely fits their definition of such a program and explains a request common to Republican governors that their state's Medicaid funding be converted into a block grant, reducing the attached coverage mandates while restoring state-level control over how the money is spent in providing health care access to their needy poor.

The development of social and economic positions by the Democratic Party has sometimes been inhibited by its efforts to include the many diverse interests of its constituency. As of late, the same can be said of the Republican Party that has had to consider and accommodate or exclude policymaking pressures exerted by both the Libertarian Party and the Tea Party movement. And, because power in Congress has become increasingly fragmented both within each dominant party and among those parties and minority parties, special interest groups have assumed a larger role in policymaking and the legislative process itself. With particular reference to health care policy, the Republicans have appeared much better synchronized and unified in ideology and purpose in their opposition to health care than the Democrats, who were divided over the extent of the federal government's role in health care and nearly failed to generate the requisite votes to pass health care reform.

The influence of the Tea Party movement on the implementation and rejection of the ACA cannot be understated. The Tea Party is generally acknowledged to be the outgrowth of grassroots opposition to federal government bailouts of financial institutions under the George W. Bush administration's TARP legislation, in response to the September 2008 financial crisis. Before 2010, the group of disaffected fiscal conservatives had no specific political agenda or policy mandate. Its focus initially was on the cost of big government. Over time, it added concerns over the diminished international standing and credibility of the United States government. Eventually, its leaders and financiers gravitated towards the president's health

222. U.S. CONST. amend. IX. The Ninth Amendment to the Constitution has been interpreted to mean that the government derives its power from the people and all powers not delegated to the government are retained by the people.

223. 2012 *Republican Platform*, *supra* note 221.

care reform agenda as the embodiment of the worst abuses of the federal government's rejection of individual rights.

At best, the Tea Party consists mostly of "cells of individuals who were angry . . . and activated by social conflicts that involve an ultimate 'scheme of values' that bring fundamental fears and hatreds, rather than negotiable interests, into political action."²²⁴ Not all Tea Party affiliates are Libertarians, nor are they all fiscal conservatives. But, collectively, they have contributed enormously to the national political debate over whether cutting government program spending is the panacea to all that ails America. The Tea Party agenda makes no attempt to address poverty, wealth disparity, or the effects of unemployment.²²⁵ It advances no health care reform goals of its own. The permanency of the movement as a fixture in the American political arena has yet to be determined, but it has had significant impact on the politics surrounding the health care debate since the 2008 presidential election.

At its nominating convention in the summer of 2008, the Republican Party embraced Sarah Palin as Senator John McCain's running mate. Governor Palin brought to the ticket populism, family values, social conservatism, political polarization, political intolerance for opposing views, and the ability of a small minority of individuals to influence the political agenda, wholly disproportionate to their small number.²²⁶ Clive Thomas likens her Tea Party impact on the health care debate to the South's ability to impose racial segregation for one hundred years after the period of Reconstruction following the Civil War, through operation of the tyranny of the minority.²²⁷

Although many suggest that the Tea Party movement is already nothing more than a footnote in American political history,²²⁸ that footnote surely attaches to the extraordinary political efforts directed towards the demise of meaningful federal health care reform. Tea Party politicians disturbed the political order in the debate process and rejected all reconciliation efforts, not only with regard to health care reform, but with respect to federal government spending in general. Candidate Sarah Palin's efforts to galvanize public sentiment against health care reform by reference to fictitious death panels succeeded in motivating opposition from conservative Republicans who harbor

224. Clodaugh Harrington, *Never mind the Details – Here's the Tea Party*, in ISSUES IN AMERICAN POLITICS 122, 123 (John Dumbrell ed., 2013).

225. See *Tea Party Movement Platform*, TEA PARTY, <http://www.teaparty-platform.com/> (last visited Mar. 24, 2015).

226. Clive S. Thomas, *The Sarah Palin Phenomenon*, in ISSUES IN AMERICAN POLITICS 135, 142 (John Dumbrell ed., 2013).

227. *Id.* at 144. Thomas references James Madison's comments on the Constitution of 1787 and its system of checks and balances to protect against the tyranny of the majority, concluding that these same checks and balances permit tyranny by the minority. *Id.*

228. See, e.g., Ernest Young, *Popular Constitutionalism and Under-enforcement*, 75 LAW & CONTEMP. PROBS. 157, 190 (2012).

religious objections to government interference in the self-determination of end-of-life treatment options.²²⁹ It also surfaced new objections from proponents of individual rights, as well as those who believe that these issues are within the exclusive province of state governments. Inspired by the acerbity of national political rhetoric, state Republican Parties adopted position statements in their 2014 political platforms advancing smaller federal government and the right of the state legislatures to ignore, oppose, refuse, and nullify federal mandate legislation perceived to infringe upon the states' Tenth Amendment rights.²³⁰

The partisan polarization of American politics began before the presidential election of 2008. However, Barack Obama's election on a high margin of party-line voting did little to moderate the lack of support from Republicans and independent voters who "perceived him as an untrustworthy radical leftist with a socialist agenda."²³¹

IX. MARSHALING THE VOTES TO REALIZE MEANINGFUL REFORM

President Obama, who was elected with 53% of the popular vote in 2008, should have been able to translate that victory into major policy changes like health care reform, which was the central theme of his campaign. But major changes in policy require public support for government action and, by 2009 and 2010, during the debate on health care reform, 40% of Americans described their political views as conservative.²³² Compromise would be required, but prove to be elusive.

In a speech delivered in Iowa City, Iowa on May 29, 2007, he issued a promise that he would later regret: "if you already have health insurance, the only thing that will change for you under this plan (to cover all Americans) is the amount of money you will spend on premiums. That will be less."²³³ He was expanding upon the DNC 2008 platform position on health care reform which included references to a belief that covering all is not just a moral imperative, but necessary to making our health system workable and affordable, and that good health is the foundation of individual achievement

229. Thomas, *supra* note 226, at 145.

230. 2014 Texas Republican Party Platform, TEX. REPUBLICAN PARTY, <http://www.texasgop.org/wp-content/uploads/2014/06/2014-Platform-Final.pdf> (last visited Mar. 24, 2015); 2014 Platform of the Kansas Republican Party, KAN. REPUBLICAN PARTY, <http://ksgop.org/wp-content/uploads/2014/04/Kansas-GOP-Platform-2014.pdf> (last visited Mar. 24, 2015).

231. George C. Edwards, *Barack Obama and the Strategic Presidency*, in ISSUES IN AMERICAN POLITICS 1, 13 (John Dumbrell ed., 2013).

232. *Id.* at 11.

233. Danny Huddleston, *Obama's Health Plan*, AM. THINKER, May 17, 2008, http://www.americanthinker.com/blog/2008/05/obamas_health.html.

and economic prosperity not only for individuals, but also for business in America.²³⁴

Once in office, President Obama chose a health reform political strategy very different from President Clinton's efforts to impose a fully developed health security act on Congress. Obama articulated broad principles for reform and allowed the Democratic leadership in both chambers of Congress to develop legislation and make the necessary political compromises to secure the votes for passage. While this strategy secured passage of the bills, the process itself exacerbated the divisions between the two political parties and unified Republican opposition to reform. Tea Party loyalists exerted considerable public and political pressure on the Republicans to accommodate their vision of a smaller federal government, including no expansion of federal funding for health care. Discussions among politicians and health-industry leaders began in earnest in the spring of 2009. Democrats offered concessions to the pharmaceutical industry in exchange for its support of changes to the Medicare Part D drug benefit and overall neutrality, if not support, for the health care reform legislation as a whole. Hospitals and physicians were also brought into the political fold with promises linked to securing their reimbursement opportunities under a reformed health care insurance market. Ultimately, the insurance lobbyists were satisfied that their clients' financial security would be assured, notwithstanding radical changes to the medical underwriting rules contemplated for the individual and small-group product markets. Republican legislators were excluded from these consultations and their participation was confined to formal committee debate and deliberation.²³⁵ This process encouraged an escalation in political rhetoric outside of the usual channels for debate, allowing for considerable misinformation to color public perception over the proposed content of the bills.²³⁶

Once critical stakeholder interests were addressed, Senator Christopher Dodd drafted Senate Bill 1679. It was referred to the Senate Committee on Health, Education, Labor, and Pensions, which conducted hearings from June 11–12, issued a formal markup, and reported SB 1679 out of the committee on July 15.²³⁷ During this same period of time, the Democratic caucus in the House was working through an outline of content for a future bill and, in mid-June of 2009, it released an 850-page discussion draft to guide negotiations

234. *Party Platforms, Election 2008*, N.Y. TIMES, May 23, 2012, <http://elections.nytimes.com/2008/president/issues/party-platforms/index.html>.

235. Robert Pear, *House Committee Approves Health Care Bill*, N. Y. TIMES, July 16, 2009, <http://www.nytimes.com/2009/07/17/us/politics/17cbo.html>.

236. See generally John Cannan, *A Legislative history of the Affordable Care Act: How Legislative Procedure Shapes Legislative History*, 105 LAW LIBR. J. 131, 144 (2013).

237. *Id.* at 146.

with members of the House.²³⁸ Over the next thirty days, Speaker Nancy Pelosi and her colleagues attempted to forge consensus among the Democratic members of the House, many of whom were withholding support out of concerns related to coverage for contraceptives, the size and cost of the reforms, and other controversial aspects of reform. A public option remained under consideration during this period, but its liberal proponents would fail to achieve the necessary sixty votes to pass it on the Senate floor.²³⁹ On July 14, House Bill 3200 was introduced and reported out to the House Committee on Education and Labor, the Ways and Means Committee, and the Committee on Energy and Commerce. Democratic leadership within the congressional committees controlled the debate and committee deliberations. On September 16, the Senate Finance Committee introduced the Senate health care reform bill, SB 1679, strategically using HR 3200 as the reported version of the legislation.²⁴⁰

Congressional leadership negotiations continued throughout the fall of 2009. On December 24, the bill finally passed the Senate.²⁴¹ But, before the legislation could be voted on by the House, a near political catastrophe was visited upon the Democrats. In a special election held in Massachusetts to fill deceased Senator Kennedy's seat, Republican Scott Brown was elected and, as of January 19, 2010, the Democrats lost their essential sixty-vote, filibuster-proof majority in the Senate.²⁴² By masterfully deploying rules to avoid the inevitable Republican filibuster, Senate Democrats convinced their colleagues in the House to enact the Senate version of health care reform with House amendments subject to the rules typically reserved for the reconciliation process used to adopt the budget. Under these rules in the Senate, amendments with fiscal consequences need only be adopted by a fifty-one-vote majority. In the House, these procedural rules limit the types of amendments that can be added to a bill.²⁴³ This reconciliation process had been tested and used successfully on other health care legislation such as Medicare reform and health insurance portability.

Of course, in maneuvering around the filibuster rules, the focus of the debate shifted to the financial consequences of every proposed change to the Senate bill. Representatives of both parties worked with the Congressional Budget Office to quantify the cost of the final political compromises necessary to obtain the votes to pass health care reform. The final version of the Patient

238. *Id.* at 137; Carrie Budoff Brown, *Lawmakers Challenged to Read Health Care Bill before Voting*, POLITICO, June 30, 2009, <http://www.politico.com/news/stories/0609/24348.html>.

239. Cannan, *supra* note 236, at 148.

240. *Id.* at 146.

241. *Id.* at 158.

242. *Id.* at 159.

243. *Id.* at 160.

Protection and Affordable Care Act was passed on March 23, 2010 and signed into law that same day by President Obama.²⁴⁴ The House amendments contained within the Health Care Education Reconciliation Act and further amendments offered on the floor of the House were passed on March 31, 2010.²⁴⁵ Collectively, these form the Affordable Care Act. But, unfortunately, the unusual political maneuvering necessary to pass the bills resulted in a sloppy drafting effort which would later jeopardize the entire ACA.

X. HEALTH CARE MARKET REFORM IN THE COURTS

Well before the final congressional votes on health care reform, public opinion polls revealed that the majority of Americans opposed the foundation of the legislation—personal and employer responsibility provisions—requiring individuals and employers to purchase health insurance or incur a financial penalty. These coverage mandates are essential to the financial integrity of the newly regulated insurance markets which are prohibited from continued reliance on medical underwriting for risk management. Between 2010 and July 2013, eighteen state legislatures passed nullification or repudiation bills, attempting to assure that their residents would be exempt from the individual mandate penalties by protecting their right to exempt themselves from the insurance market altogether.²⁴⁶ After passage of the ACA, the administrative rule-making process caused thousands of pages of additional regulatory detail to be considered and debated, providing additional avenues of input and guidance to health care providers, insurers, employers, and state governments, all with vested interest in the finer details of the implementation process. Positions were refined and public and political objections intensified. House Republicans voted over one hundred times to repeal the legislation.²⁴⁷ Republican committee chairs in Congress initiated “accountability” hearings, seeking to hold the heads of federal administrative agencies responsible for overly zealous interpretations of the ACA under their rulemaking authority, impermissible delays in implementation, and failed execution. Implementation delays were extended by the Obama administration, in part out of practical necessity, but also in response to mounting opposition by employers and politicians concerned over the immediate effects of employer coverage

244. *Id.* at 165.

245. THE PRESIDENT SIGNS H.R. 4872, THE “HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010”, SSA 111-41 (Mar. 31, 2010), *available at* http://www.ssa.gov/legislation/legis_bulletin_033010.html.

246. *See* RICHARD CAUCHI, NAT’L CONFERENCE OF STATE LEGISLATURES, STATE LAWS AND ACTIONS CHALLENGING CERTAIN HEALTH REFORMS (2014), <http://www.ncsl.org/documents/summit/summit2013/online-resources/State-Legislation-Opt-out.pdf>.

247. Sophia Pearson & Kathleen Miller, *House Republicans Sue Obama Over Health Law Implementation*, BLOOMBERG BUSINESSWEEK, November 22, 2014, <http://www.bloomberg.com/news/2014-11-21/congress-sues-obama-naming-health-treasury-departments.html>.

mandates on a fragile economy.²⁴⁸ These delays, in combination with opposition litigation victories, created unacceptable business uncertainty for employers and insurers. Decisions made by state legislatures to reject state-level cooperation and participation in the establishment of a model state health plan, to develop a state-supported, market-based exchange for the sale of new individual and small-group health plans, and to provide any assistance to state residents attempting to avail themselves of the benefits of federal health care reform added to the confusion over the permanency of the law.

The very day that President Obama signed the ACA into law, thirteen state attorneys general, later joined by another thirteen, began their quest to obtain a judicial determination that the ACA is unconstitutional.²⁴⁹ Led by the attorney general of the state of Florida, the states challenged the constitutionality of the individual mandate and the expansion of the Medicaid program.²⁵⁰ The administration sought Supreme Court review of the adverse ruling of the Eleventh Circuit Court of Appeals, which held that the coverage mandate was unconstitutional but severable from the ACA, thus preserving Medicaid expansion and the balance of the act. The Florida case was joined with two other pending challenges to the ACA in a consolidated appeal in the matter of *National Federation of Independent Business v. Kathleen Sebelius*.²⁵¹ On June 28, 2012, the United States Supreme Court issued its long-awaited opinion on the constitutionality of the ACA. It upheld the constitutionality of the ACA's individual coverage mandate under the congressional power to levy taxes, while striking the expansion of the Medicaid program as unduly coercive under the Tenth Amendment.²⁵² The decision also resolved challenges to the mandate under the commerce clause and the Anti-Injunction Act,²⁵³ while addressing severability of the Medicaid coverage expansion in order to preserve the

248. *Id.*

249. *Florida v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235, 1240 (11th Cir. 2011), *aff'd in part, rev'd in part sub nom.*, *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012).

250. *Florida ex rel. Bondi v. U.S. Dep't of Health & Human Servs.*, 780 F. Supp. 2d 1256 (N.D. Fla.), *order clarified*, 780 F. Supp. 2d 1307 (N.D. Fla. 2011), *and aff'd in part, rev'd in part sub nom.*, *Florida ex rel. Atty. Gen. v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235 (11th Cir. 2011), *aff'd in part, rev'd in part sub nom.*, *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 183 L. Ed. 2d 450 (2012). Florida was joined in this litigation by the states of Alabama, Alaska, Arizona, Colorado, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Nebraska, Nevada, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Washington, Wisconsin, and Wyoming. Iowa and Washington were represented on both sides of the dispute; their Republican attorneys general were party plaintiffs and their Democratic governors filed amicus briefs supporting the individual mandate and expansion of Medicaid.

251. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 U.S. 2566, 2578 (2012).

252. *Id.* at 2573.

253. *Id.* at 2591.

balance of the statute. The various opinions of the Court reflect the same ideological and political philosophies that have shaped the public debate over health care reform. Moreover, they invoke historical divisions on federalism, dual sovereignty, and the role of the judiciary in resolving controversial social issues, dating from the time of the Civil War.

Writing for a five-to-four majority, Chief Justice Roberts analyzed the individual coverage mandate under the commerce clause and the necessary and proper clause, concluding that neither provision supports a coverage mandate which, by its nature, is not commerce.²⁵⁴ Because the Constitution does not regulate inactivity, Congress exceeds its authority by attempting to compel commerce. The individual mandate requires most individuals to maintain a minimum level of health insurance coverage beginning in 2014.²⁵⁵ Approximately nine out of ten Americans were in compliance with this provision before 2014, either because they were insured through their employers or are exempt by the terms of the statute.²⁵⁶ Individuals who fail to secure minimum essential health coverage owe a financial penalty, referred to as the “shared responsibility payment.”²⁵⁷ The penalty does not render the state of “uninsurance” to be unlawful.²⁵⁸ Rather, the Internal Revenue Service collects the penalty as an adjustment to filed federal income tax returns.²⁵⁹ The Court considered whether the penalty specified under the law was properly viewed as a tax. When viewed as a tax, the constitutionality of the provision could be considered under the taxing authority of Congress, rather than the more restrictive commerce clause, which then enabled the Court to adopt an interpretation that saved the act from constitutional infirmity.²⁶⁰

Chief Justice Roberts was joined by Justices Breyer, Kagan, Ginsburg, and Sotomayor in holding that the individual mandate is a constitutional exercise of Congress’s broad power to levy taxes, under Article I, Section 8, Clause 1.²⁶¹ This determination overcame the principle objection to the mandate as government intrusion into commercial inactivity because the power to tax extends to commercial inactivity.²⁶² The chief justice was joined in a different majority by Justices Scalia, Kennedy, Thomas, and Alito, finding the individual mandate unconstitutional under the commerce clause and the

254. *Id.* at 2593.

255. *Id.* at 2580.

256. HENRY J. KAISER FAMILY FOUNDATION, A GUIDE TO THE SUPREME COURT’S AFFORDABLE CARE ACT DECISION 2 (2012), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8332.pdf>.

257. *Id.*

258. *Id.*

259. *Id.*

260. *Id.*

261. Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 U.S. 2566, 2590 (2012).

262. *Id.*

necessary and proper clauses.²⁶³ The remaining four justices, Kagan, Breyer, Sotomayor, and Ginsburg, in a dissenting opinion, found that Congress had a rational basis for determining that the uninsured as a class substantially affects interstate commerce, and further, that the mandate is reasonably necessary to the goal of assuring effective functioning of health care markets.²⁶⁴

With regard to the expansion of the Medicaid program, the ACA initially provides 100% federal funds for expanded eligibility and coverage costs, tapering off to 90% federal funding from and after 2020.²⁶⁵ Any state's rejection of the expanded coverage and eligibility provisions would cause forfeiture of all federal Medicaid funding to that state. In a seven-to-two decision, the Court found that the expansion added 40% higher costs, or approximately \$100 billion per year, to the administration of the program.²⁶⁶ Given the extent of the program, Medicaid payments issued by the federal government to the states exceed 20% on average of each state's total annual budget. Moreover, federal Medicaid grants to the states cover between 50% and 83% of each state's annual spending on health care and related services for its Medicaid-enrolled population.²⁶⁷ Congress included Medicaid program expansion as part of a comprehensive effort to provide health care access to the uninsured, approximately half of whom qualify by virtue of income, for enrollment in the means-tested Medicaid program.²⁶⁸ Medicaid expansion complements the availability of subsidized private insurance available through state-level health insurance exchanges, as part of a comprehensive system providing access to coverage for individuals based on financial need. Because the ACA puts all state Medicaid funding at risk when states fail to participate voluntarily in the expanded portions of the Medicaid program, this provision in the act was found to be unduly coercive and a violation of the congressional spending authority.²⁶⁹

The dissenting opinion, authored by Justice Ginsburg, provides a comprehensive economic rationale for health care reform while finding support in the commerce clause for its constitutionality. She notes that 85% of all health care in America is financed by private health insurers and state and federal governments. For the remaining uninsured 15%, their inability to personally finance needed health care services results in a free ride, shifting costs to insured participants and adding costs to the system attributable to their lack of direct access to primary care services, resulting in repeated high-cost

263. *Id.*

264. *Id.*

265. 42 U.S.C. § 18001 (2010).

266. *Nat'l Fed'n of Indep. Bus.*, 132 U.S. at 2590.

267. *Id.* at 2604 (citing 42 U.S.C. §1396(d)(b)).

268. *Id.*

269. *Id.*

treatment of acute exacerbations of chronic conditions in hospital emergency department settings.²⁷⁰ She concludes that states are unable to provide universal access to health care without suffering the undesirable consequence of adverse selection of unhealthy patients migrating from other states solely to obtain access to state-subsidized health care services.²⁷¹ The element of economic disadvantage among the states explains why states have generally rejected coverage mandates and provides appropriate context for congressional action. With regard to Medicaid expansion, Justice Ginsburg concludes that states embraced the concept of cooperative federalism when initially deciding to participate in the Medicaid grant program, allowing states to provide for the general welfare of their citizens by accepting federal grant money and tailoring its application to their needs.²⁷² She finds that all states had committed to amending their own Medicaid plans in a manner consistent with changes implemented by Congress under its statutorily reserved amendatory powers.²⁷³ Moreover, federal funding of all Medicaid program benefits has always represented 50% or more of each state's costs, so from the dissenting perspective, the ACA Medicaid expansion was merely a change of degree not substance.

The dissenting opinion of Justices Scalia, Kennedy, Thomas, and Alito presents a contrasting perspective on federalism and the limits of the commerce clause. They note that the commerce clause has never before been extended to impact a failure to take action as the majority opinion in the *NFIB* case would require.²⁷⁴ And, they express the fear that if the coverage mandate is upheld under the commerce clause, then its reach extends to all private conduct, including an individual's inaction.²⁷⁵ Citing recent judicial constraints on the application of the commerce clause, limits have been established and should be preserved with regard to activity that does not directly regulate the interstate markets or its participants.²⁷⁶

This same view of a limited federal government permeates the dissenters' review of the Medicaid expansion issue. They begin with a reference to *South Dakota v. Dole*,²⁷⁷ in which the Court previously held that generally, conditional federal grants to the states are constitutional.²⁷⁸ In *Dole*, they note

270. *Id.*

271. *Id.*

272. *Nat'l Fed'n of Indep. Bus.*, 132 U.S. at 2632.

273. 42 C.F.R. § 430.12 (2011); 42 U.S.C. § 1304 (2012).

274. *Nat'l Fed'n of Indep. Bus.*, 132 U.S. at 2642.

275. *Id.*

276. *Printz v. United States*, 521 U.S. 898, 900 (1997) (explaining that Congress cannot, in an effort to regulate the distribution of firearms in interstate markets, compel state law-enforcement officials to perform federal background checks).

277. *South Dakota v. Dole*, 483 U.S. 203, 206 (1987).

278. *Id.* at 207.

that objectives thought to be within Article I's enumerated legislative fields may nevertheless be attained through the use of the spending power and the conditional grant of federal funds.²⁷⁹ However, the dissenters find a limit to the inducements, measured by the point at which they cross over into an area of coercion.²⁸⁰ They measured the ACA Medicaid expansion provision and found that it offered no real choice to the states to accept or reject the offer, as required under the contract-like relationship specified under the Constitution for the federal and state governments.²⁸¹ Congress cannot commandeer the legislative process reserved as a sovereign power of the states by compelling them to enact and enforce a federal program like Medicaid, citing *New York v. United States*.²⁸² They further note that a good reason to hold the federal government solely accountable for unpopular decisions like the Affordable Care Act is to preserve the peoples' remedy to remove individuals from elected office, presumably by imposing a clear line of sight to those who should be held accountable.²⁸³ The dissent concludes with a reference to *South Dakota v. Dole*, that if the states have no choice but to accept, the federal offer is coercive and an unconstitutional exercise of the congressional spending power.²⁸⁴

After the *NFIB* constitutional challenge, the Court next took up a challenge arguing that the ACA requirement that access to contraceptives be included free of charge in ACA compliant health plans violated the exercise of religion protected under the Religious Freedom Restoration Act of 1993 (RFRA). Hobby Lobby and three other closely-held, for-profit corporations, through their owners, claimed that the regulations established under the ACA applicable to large-employer group health plans include a requirement that these employers furnish preventive care and screening services for women without cost sharing within their group health plans.²⁸⁵ On the list of twenty preventive services that must be covered without copayment or deductible expense are four intrauterine devices that prevent a fertilized egg from attaching to the lining of the uterus.²⁸⁶ The owners of the four closely-held corporations claimed that they are exempt from compliance with this provision of the ACA under the RFRA based upon the owners' "sincere Christian belief that life begins at conception" and to require them to purchase life-terminating health care services under their group health plans impermissibly interferes

²⁷⁹ *Id.*

²⁸⁰ *Nat'l Fed'n of Indep. Bus.*, 132 U.S. at 2661.

²⁸¹ *Id.* at 2662.

²⁸² *New York v. United States*, 505 U.S. 144, 161 (1992).

²⁸³ *Nat'l Fed'n of Indep. Bus.*, 132 U.S. at 2667.

²⁸⁴ *Id.*

²⁸⁵ *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751 (2014).

²⁸⁶ 42 U.S.C. § 18021 (2010).

with their right to conduct their business affairs in accordance with their religious beliefs.²⁸⁷

In *Burwell v. Hobby Lobby*,²⁸⁸ Justice Alito, writing for a majority of five justices, agreed that closely-held corporations qualify as persons and that the Health and Human Services Department rules failed to adopt the “least restrictive means” to further cost-free access to contraceptives. Accordingly, the implementation rules affront the protections enjoyed by business owners under the RFRA. Not surprisingly, the four justices who dissented in *NFIB* declined this reasoning, expressing concerns that the majority was opening the door to allow any commercial enterprise to opt out of compliance with the non-tax-based provisions of the ACA, if those business entities found the provisions to be incompatible with their sincerely held religious beliefs.²⁸⁹

The latest ACA appeal to find its way to the Supreme Court involves a question of whether the Internal Revenue Service correctly discharged its rulemaking authority when determining that Congress intended that premium subsidies be extended to consumers purchasing health insurance products in markets established by the federal, rather than state, governments.²⁹⁰ This issue impacts more than four million consumers and billions of dollars in federal premium subsidies. In *King v. Burwell*, the Supreme Court granted a writ of certiorari arising out of a July 22, 2014 determination by a three-judge panel for the Fourth Circuit Court of Appeals, which affirmed a district court decision that the language of the Affordable Care Act is ambiguous.²⁹¹ The Fourth Circuit panel deferred to the rulemaking authority of the Treasury Department and its expertise in interpreting and applying the Tax Code.²⁹² Accordingly, the panel held that the IRS acted within its authority when applying subsidies to products sold on the thirty-four federally facilitated, partnership-type exchanges. Petitioner-appellants assert that this interpretation is not supported by the plain language in the text of the statute, which limits the tax credit to taxpayers enrolled through an “exchange established by a state under Section 1311.”²⁹³ Accordingly, in support of immediate Supreme Court review, they argue that billions of dollars in unauthorized subsidies have been, and will continue to be, paid by the federal government to millions of consumers who have purchased ACA products on one of thirty-four exchanges administered in whole or in part by the federal government, rather than state

287. *Hobby Lobby*, 134 S. Ct. at 2759.

288. *Id.*

289. *Id.* at 2787.

290. *See King v. Burwell*, 135 S. Ct. 475 (2014).

291. *Id.*

292. *King v. Burwell*, 759 F.3d 358, 376 (4th Cir. 2014).

293. *Id.* at 365.

governments.²⁹⁴ If the Supreme Court chooses to apply rules of statutory construction that examine the context for the challenged phrase, the two Acts, PPACA and HCERA, will confound that analysis due to inconsistent references and inelegant drafting of language. Moreover, the legislative history offers contradictory and politically motivated rationale for the failure to explicitly reference federally established exchanges in the authorization for premium subsidies. The Internal Revenue Service provided minimally adequate support for its interpretation, providing little detail for the review of its actions. Clearly, the political process that produced the ACA created an inconsistent and unreliable record for Supreme Court review.

Although the legal issue presented is relatively straightforward, a decision by the highest court adopting the losing side's view could have dire consequences for the survival of the ACA, which of course, is precisely the purpose of this litigation and many other cases pending around the country. Without premium assistance, lower-income Americans are unlikely to afford the health insurance products currently available through the new exchange markets. Returning millions of individuals to the status of "uninsured" not only undermines the purpose of health care reform, but also compromises the financial viability of remaining risk pools. The individual coverage mandate and premium subsidies work in combination to ensure that the sale of new insurance products creates a balanced pool of insurance risk. When either essential element of reform is compromised, costs will rise unacceptably to offset the loss of lower-risk insureds who enrolled for reasons other than immediate medical need. A recent RAND study estimated that the loss of federal subsidies would have the effect of raising premium costs for individual products by 43%.²⁹⁵ Moreover, a ruling that impairs the affordability of the exchange products will excuse compliance with the individual and employer coverage mandates and precipitate losses for both the insurance industry and individual states that will return to the business of subsidizing the cost of charity care for uninsured residents.

King v. Burwell and a similar case pending in the D.C. Circuit, *Halbig v. Burwell*,²⁹⁶ where the Court determined that vacation of the IRS action was necessary because the rule contravened the unambiguous language of the statute, reached opposite conclusions with regard to appropriate remedies to resolve ambiguity of the phrase in question. Each was decided by three-judge panels and the losing parties in both cases sought *en banc* review.

294. Brief for Petitioner at 22, *King v. Burwell*, 135 S. Ct. 475 (2014) (No. 14-114), 2014 WL 3817533.

295. *Eliminating Subsidies for People to Buy Health Coverage Would Increase Premiums and Number of Uninsured*, RAND CORP., Oct. 21, 2014, <http://www.rand.org/news/press/2014/10/21.html>.

296. *Halbig v. Burwell*, 758 F.3d 390, 394 (D.C. Cir. 2014).

Uncharacteristically, the Supreme Court agreed to hear the appeal before either *en banc* review. At issue are the remedies appropriate to the resolution of language ambiguity impacting millions of Americans. The *King* appellants argue for vacation of the IRS rule, seeking the return to the federal treasury of 2014 advance premium credits already paid to the insurers on behalf of the five million consumers who purchased subsidized health insurance through Healthcare.gov, the federal government's website operated in partnership with, or on behalf of, thirty-four states.²⁹⁷ The IRS determined that Congress intended that exchanges established by the federal government under ACA § 1391 are, nonetheless, exchanges "established by the states" under ACA § 1311(b)(1), in those instances where states refused to adopt their own exchanges or failed to meet the 2014 deadline to launch their own exchanges.²⁹⁸ The Court was persuaded to accept the appeal before full review in these two cases as well as a third appeal pending before the Tenth Circuit Court of Appeals. Ironically, if subsidies are confined to residents of the sixteen states and the District of Columbia, politicians in the remaining states will be held accountable for their earlier decisions to forego the funding and development of their own state-based exchanges, now necessary to preserve resident access to premium assistance under the ACA.

Clearly, the United States Supreme Court is not done with the ACA. Nor have the opponents of the ACA filed their last legal challenge to the law.²⁹⁹ Lawsuits will continue to chip away at unpopular provisions of the act, hoping ultimately to convince the Supreme Court to invalidate the entire ACA. Legal challenges will seek to constrain the exercise of administrative discretion with regard to incremental implementation of the many working parts of the legislation. In that regard, politics and the law converge to curb the undesirable political effects of the implementation process itself.³⁰⁰

297. In 2014, there were seventeen marketplaces run by individual states and the District of Columbia. Premium subsidies paid to consumers in those states would not be directly affected by the Court's decision in *King*.

298. *King v. Burwell*, 759 F.3d 358, 369 (4th Cir. 2014).

299. Recent filings include an action filed on July 29, 2014 in the United States District Court for the District of Columbia by the state of West Virginia, asserting a return to the rule of law and curtailment of the president's persistent and unilateral efforts to suspend the Tenth Amendment and established law to overcome through administrative "fixes" politically inexpedient implementation problems under the ACA. The allegations mirror complaints heard in the political arena that the administration is attempting to deflect criticism for the unpopular portions of the reform act by shifting political accountability to the Republican Party. Petitioner's Complaint, *West Virginia ex rel. Patrick Morrissey v. U.S. Dep't of Health & Human Servs.*, Civil Action No. 14-1287 (2014).

300. Petitioner's Complaint, *West Virginia ex rel. Patrick Morrissey v. U.S. Dep't of Health & Human Servs.*, at para. 3, 5, 65, 71, Civil Action No. 14-1287 (2014) (alleging that the Obama administration abandoned the "rule of law" when issuing the Administrative Fix, suspending and

The Republican Party consolidated its majority position in both chambers of Congress during the elections of November 2014, and at the state level, Republicans maintained majority control over state executive and legislative positions. It is fully anticipated that Congress will continue to vote for repeal of this administration's signature legislation. It is also probable that President Obama will veto any efforts to eviscerate the law so long as he remains in office. The more fractious element of the majority party has a solution for that problem as well, and will encourage the filing of Articles of Impeachment. Short of repeal, Republican leadership has expressed an interest in eliminating the 2.3% excise tax imposed on the medical device industry, defunding the statutory reforms by \$29 billion over the next ten years.³⁰¹ A Republican study committee has created H.R. 3121, entitled the "American Health Care Reform Act," recognizing that "patient-centered reforms rooted in free markets are the best way to lower costs and solve problems in our health care system."³⁰² This group of conservative Republicans proposes repeal of the ACA and replacing that act with a tax-based alternative providing access to a more competitive health insurance market that eliminates geographic restrictions and expands the use of private health savings accounts to help individuals finance the cost of health care services.

Whether political efforts to repeal and replace the basic principles embodied in the ACA vision of expanded and virtually universal access to health care are incremental or holistic in focus, it appears likely that they will continue, notwithstanding resolution of the legal challenges. America is clearly experiencing disunion over its response to the health care funding crisis. Faith in the American economy and the ability of free markets to rectify any imbalance in the distribution of health care services discourages meaningful national solutions for those for whom private health insurance is unaffordable at essentially any price. If the debate is resolved in a manner favoring the sovereignty of the states over health care access and financing issues, then

amending provisions of the ACA, thus requiring states to enforce the ACA, thereby shifting political accountability for unpopular provisions of the law).

301. The American Health Care Reform Act, H.R. 3121, 113th Congress (2013). Drafted as the Republican's 2014 alternative to the ACA, the act would repeal the excise tax, coverage mandates, and all funding of comparative effectiveness research, while expanding the use of health savings accounts and standardized payroll and income tax deductions to offset newly taxed health insurance benefits. This replacement legislation federalizes health insurer regulation and the sale of products across state lines. In many respects, it represents a more radical change to health insurance markets than the ACA. Yet, its mere existence reflects the political reality that if the Affordable Care Act is repealed, millions of Americans will lose access to health care and seek to hold someone accountable for their losses.

302. *American Health Care Reform Act*, <http://rsc.flores.house.gov/solutions/rsc-better-way.htm> (last visited Mar. 24, 2015).

local politicians will be challenged to develop appropriate local solutions for which they will be held accountable.

XI. CONCLUSION

As noted by dissenting Justices Scalia, Kennedy, Thomas, and Alito in *NFIB v. Sebelius*:

Those States that decline the Medicaid Expansion must subsidize, by the federal tax dollars taken from their citizens vast grants to the States that accept Medicaid Expansion. If that destabilizing political dynamic, so antagonistic to a harmonious Union, is to be introduced at all, it should be Congress, not the Judiciary. The values that should have determined our course today are caution, minimalism, and the understanding that the Federal Government is one of limited powers. . . . In the name of cooperative federalism it undermines state sovereignty. . . . The fragmentation of power produced by the structure of our Government is central to liberty, and when we destroy it, we place liberty at peril.³⁰³

Similar perspectives on disparities in economic interests between the Northern and Southern states shaped the political debate during the antebellum period and led to the development of judicial doctrine limiting the constitutional authority of Congress to regulate commerce among the states. The five-to-four majority decision in *NFIB* upheld the constitutionality of the individual mandate provisions of the ACA under the broader necessary and proper authority granted to Congress, while determining that congressional power to regulate commerce is limited to activity, rather than the inactivity of recusing oneself from the insurance market. This ruling will fail to placate those who assert individual liberty objections to having to choose between buying an unwanted product and paying a penalty to the federal government. Likewise, the majority decision on Medicaid will be unappreciated and criticized by state governments unable to offer alternative financing models to replace the federal promise of expanded coverage for state residents under the federal Medicaid program. Moreover, as noted by the dissent in *NFIB*, the failure of state officials to expand Medicaid eligibility under the ACA on a voluntary basis creates potentially untenable political pressure linked to foregone opportunity and loss of additional federal tax dollars flowing back to the states under the Medicaid program.

The Supreme Court acknowledged the political challenges presented by health care reform, driven in large measure by the enormity of the financial consequences of congressional interference in the markets that comprise major portions of federal and state budgets. The philosophical and ideological divide over this issue is no less dramatic than the economic challenges that led to the

303. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2676–77 (2012).

Civil War. And, although tensions linger over the intersection of boundaries in our system of dual sovereignty, in the interim, we have established and accepted a working order of authority under our Constitution—an order determined by the judiciary, not the politicians. On the other hand, the judiciary reflects the cultural views of American society. In that regard, resolution of politically motivated legal challenges to the ACA does little to address and resolve underlying cultural and economic tensions linked to highly controversial and unpopular legislation. We will avoid another Civil War, but at what cost?

It appears that we are destined to experience a period similar to post-Civil War Reconstruction where distrust and refusal to compromise impeded meaningful reform and recovery. Conflicting positions on individual liberties and states' rights will be argued in support of a return to the *status quo ante* in which health insurance is a commodity available to those who can afford the coverage. Conservatives will complain about the ever-expanding cost of health care and encourage the natural evolution of a market free from government regulation as the most appropriate means to competitively lower costs. And, along the periphery, matters of religious conscience and morality will permeate the debate as deemed politically expedient. It is no wonder that compromise is so elusive given the acerbity of the rhetoric and the cost of the solution. Perhaps the health care delivery system will solve the immediate affordability crisis by voluntarily reducing cost without government assistance. If not, a solution that provides more meaningful opportunity for better health will have to await a consensus. We can no longer afford to perpetuate an expanding health care economy that places access to needed health care services beyond the reach of millions of Americans. At the moment, all indicators point towards a contentious and protracted period of continuing debate. Did we learn nothing from the Civil War?

